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THE JOURNAL

OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

CORONARY ARTERY BYPASS SURGERY

MULTIPLE PRIMARY CANCERS

ACUTE CARE BED NEED IN SOUTH CAROLINA

THE OPERATING ROOM: HISTORICAL PERSPECTIVE

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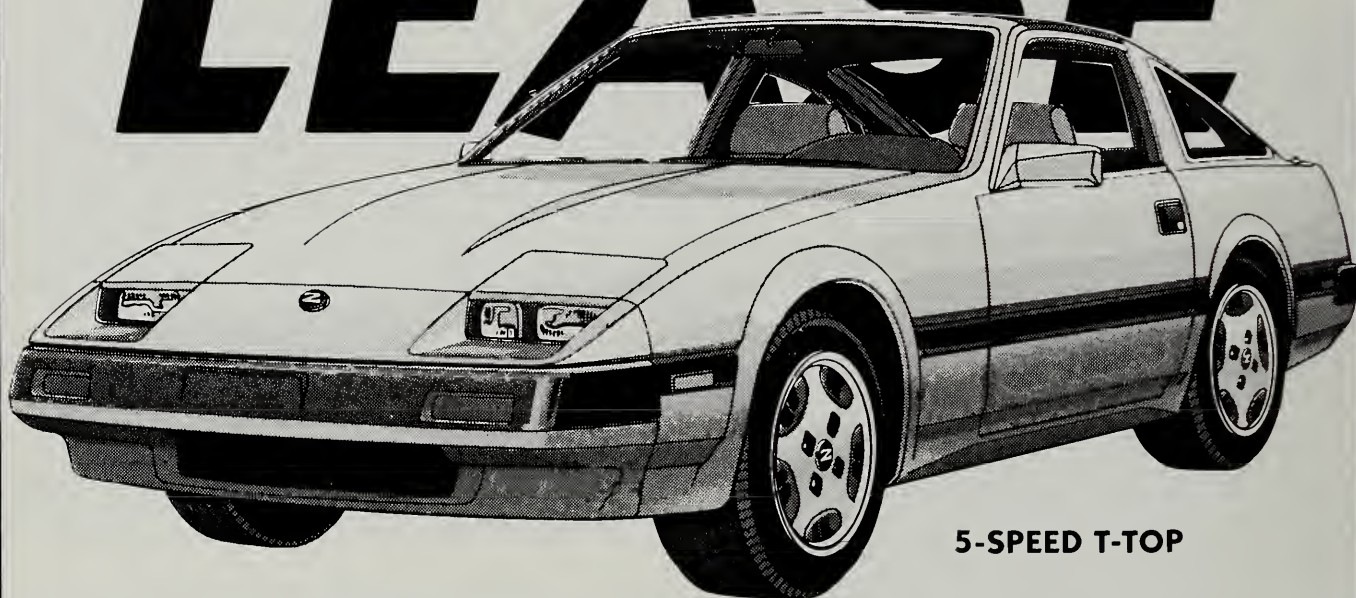
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President's Page



THOUGHTS FROM THE AMA MEETING

Having recently returned from the AMA Interim Meeting in Hawaii, I have fond memories of this meeting and its accomplishments. The address of the President, Joseph F. Boyle, M.D., was thought-provoking and forceful. He again challenged and chastised physicians. Our own Billie Brady spoke to the House on the many objectives and accomplishments of the Auxiliary, and particularly offered to assist in any way with education, distribution or support (moral and physical) in our nationwide struggle to change or alter the professional liability climate.

AMA-ERF President, Dr. Rufus Bradaway, declared that the number of contributions was increasing and urged all members to contribute and allow credit to be extended for these contributions to the Auxiliary. AMPAC Chairman, Fred Rainey, M.D., stated that 82 percent of candidates supported were elected and that AMPAC was *truly bipartisan*.

I happened to listen to a debate on Channel 17 (Atlanta) of the House of Delegates' decision to support the Resolution to ban boxing. The AMA was maligned for meeting in Hawaii and criticized for not also supporting banning all violent sports including football, basketball and baseball. It was suggested that anyone who went to Waikiki Beach would have voted in favor of any Resolution. I find this remark by the former Editor of *Ring Magazine* to be both obnoxious and disrespectful in suggesting that the members of the House would support anything simply because of the area in which we met. He further suggested that if our decision had been made in Cleveland it would have been more effective.

The House of Delegates of the American Medical Association is a more democratic body than any I have ever witnessed. I believe that we should endeavor to implement every improvement in any sport which would diminish the possibility of injury or death; however, I must also state that we must be prepared to justify whatever approach we take. If banning boxing is the way to stop senseless injury and death, then perhaps we should ban automobiles; many more lives are lost because of careless or incapacitated drivers. Although I must profess to little enthusiasm for the sport of boxing, I believe we must support the decision of the House. I also do not believe that we will be successful if what is to be sought is a legislative ban — this is one of those decisions which is in the "no win" category.

A Resolution presented by the American Academy of Family Physicians, if passed in its original form, would *require* that Family Medicine be taught as a specific subject in medical school. There was extensive debate in the Reference Committee, with the result that the wording was changed to *urge* the schools to offer a course in Family Medicine. The matter of a specialty publication in OB/GYN was referred to the Board of Trustees.

Many other items were considered, and had it not been for the diligence of the House on Tuesday afternoon, the meeting could not have adjourned by Noon on Wednesday — all in all a very pleasant experience.

Until next month,

A handwritten signature in dark ink, appearing to read "Ken", with a long, sweeping horizontal line extending to the right.

KENNETH N. OWENS, M.D.
President



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INFORMATION FOR AUTHORS

Authors should refer to the detailed instructions in the January issue. Manuscripts and other correspondence should be addressed: The Editor, JOURNAL OF THE SOUTH CAROLINA MEDICAL ASSOCIATION, Post Office Box 11188, Columbia, S. C. 29211.

All manuscripts should be accompanied by a transmittal letter with the following paragraph: "This original work has not been submitted or published elsewhere, in entirety or in part. I (we) hereby transfer, assign, or otherwise convey all copyright ownership to the South Carolina Medical Association in the event that this work is published by the SCMA."

We request that manuscripts be concise (no longer than 8 typewritten pages, double-spaced), with no more than ten references. These should be cited in the text in superscript, e.g., "Bottsford, et al.³", and should conform to the following style: "3. Bottsford JE, Bearden RC, Bottsford JG: A ten year community hospital experience with abdominal aorta aneurysms. *J S C Med Assoc* 79: 57-62, 1983." Ordinarily, publication of four small illustrations or tables or the equivalent will be paid for by *The Journal*. Manuscripts should be submitted in duplicate. Reprints will be made available by the publisher.

From the State House: LEGISLATIVE UPDATE



January 1985

The 1985-86 Legislative Session will have begun by the time this update reaches you. Foremost on the agenda in the coming year will be debates on the newly proposed indigent care plan, adequate funding to settle lawsuits and other concerns surrounding conditions at our state-run prison system, and how to go about spending the relatively modest 80 to 100 million dollars in estimated new revenues. In other words, money matters should be the major topics this year.

CONFIDENTIALITY BETWEEN PHYSICIAN & PATIENT

South Carolina remains one of the ten-odd states which does not have a provision in the state law protecting the communications between patients and physicians. This has led to some situations of abuse, where physicians have been forced to reveal matters involving their patients to the court. This violates medical ethics and, of course, tends to break down the relationship between patient and doctor to the detriment of correct diagnosis and treatment.

SCMA precipitated the introduction of legislation to have such a provision enacted in 1984; however, certain attorney groups successfully utilized the parliamentary process to stall and eventually kill all chances of passage into law. That bill would have provided that confidential communications properly entrusted to "physicians" (and other health care professionals) are privileged and cannot--except in exceptional circumstances--be subject to disclosure or testimony in court proceedings.

We will once again attempt to have a bill considered and passed to provide for appropriate confidentiality. If you, the physician, have an attorney or attorneys in your local legislative delegation, approach them and ask them to study the bill carefully this year without automatically voting against it. We feel this legislation, as currently drafted, affords adequate opportunities for appropriate medical/health evidence to come before the court when necessary, yet affords protection when no valid reasons exist to invade the patient's privacy.

EFFORTS TO DELETE M.D. REQUIREMENT FOR COMMISSIONER OF MENTAL HEALTH

Various legislators failed last year in their attempts to do away with a Statutory provision which requires that an M.D. serve as the Commissioner of the State Department of Mental Health. The Commissioner oversees the various hospitals which house our state's mentally ill population. A bill (H-2864) that would accomplish this purpose never even came to a vote on the House floor, and in the waning days of the '83-'84 session attempts were made to attach a "rider" to the state budget bill to accomplish this purpose. This attempt also failed.

What did pass into law was a provision stipulating how a replacement would be found for the retiring Commissioner—a task force or committee made up largely of government-types which would scrutinize etc., candidates for the job.

What is extremely disappointing is that this committee has sat on its hands since its creation in early summer of '84. Reportedly the Search Committee will continue to drag its feet, hoping that certain legislators will get a bill passed early in this session deleting the M.D. requirement. Apparently there is little intention of searching for an M.D. to fill this position as the legislators involved take the viewpoint that all M.D.'s are "poor administrators."

Talk to your local House & Senate members about this issue because the handwriting on the wall indicates another push to ensure that a professional (and non-M.D.) bureaucrat runs the Department of Mental Health in the future.

MORE GROUPS LINING UP TO GAIN "LICENSURE"

State House watchers have viewed a predictable pattern with professional and semiprofessional groups pushing to become a "licensed profession"—especially in regard to paramedical groups. They always approach legislative bodies arguing that some in and out of their particular profession could do great harm unless a board made up from that group was legislatively created to oversee the profession.

This pattern that is seen usually presents itself in the following order: 1. The group receives formal government recognition by the state of the practitioner group and of the need to regulate the practice in the "public interest" either by registration, certification, or licensure; 2. Scope of practice—the nature and boundaries of the practitioners' "practice" (usually denied to others) is defined usually in the form of expansion of the original scope of practice into additional services involving presumed higher levels of education, training, skill, judgment, and remuneration; 3. Practice Autonomy—the extent to which the practitioner may provide services directly to the public and independently of any other practitioner, in the absence of requirements for the referral, approval, consultation, supervision or direction of another is set forth; 4. Third Party Reimbursement—legislation is enacted reflecting the various methods of encouraging or assuring payment by third parties for services rendered by the practitioner to the public, including government or private insurers, such as non-discrimination, "mandated lifting," "mandated offering," or "mandated coverage" provisions; and 5. Hospital Admitting Privileges—a legislative or court-oriented push for the authority of the practitioner to utilize the facilities and resources of a hospital for the delivery of services, either independently or conditionally.

This development always serves the particular professional group and its interests well, but the public is often ill served—especially since costs tend to rise with professional licensure. Studies also reflect that these groups often tend to protect their own and utilize their best efforts mainly to keep others and the "part-timers" out of business.

The social workers have, for several years, been attempting to gain licensure in South Carolina. In anticipation of the upcoming session, they were claiming that since the legislature last year listed them as an "Examination Board" in the State Budget bill, they now have the right to "license" instead of "register" social workers. Even their leadership has admitted that a chief goal of licensure is to gain third party reimbursement. The public at large will surely pay more if that ever becomes the case. On the eve of the opening of the 1985 session their Board abruptly rescinded these proposed regulations. We are not certain as to what will be their next move: however, we know only too well their ultimate desires.

As was the case last year, we fully expect to, again in the upcoming session, hear from social workers. Likewise, we also expect the respiratory therapists, occupational therapists, "counselors", and "family therapists" to come forth asking for licensure. Their goals, of course, are working down the five-step procedure listed above.

SAFETY OF COMBINED CORONARY ARTERY BYPASS SURGERY*

L. DIETER VOEGELE, M.D.**

WILLIAM H. PRIOLEAU, JR., M.D.

PETER HAIRSTON, M.D.

The safety of coronary artery bypass graft surgery (CABG) combined with resection of ventricular aneurysm, repair of post-infarction ventricular septal defect, aortic valve replacement, mitral valve replacement, simultaneous carotid endarterectomy, and ascending aortic aneurysm repair was reviewed in 55 patients. Twenty-five patients underwent concomitant aortic valve replacement, 14 patients ventricular aneurysm resection, six patients each simultaneous carotid endarterectomy and mitral valve replacement, one patient ascending aortic aneurysm repair and three patients underwent ventricular septal defect closure.

Bypass grafting of atherosclerotic obstructed coronary arteries has become a well-established surgical procedure in many centers today, with an operative mortality ranging from less than one percent to 10 percent for elective, routine revascularization cases.¹ However, concomitant operations for other cardiovascular pathology, in particular the life-threatening complications of myocardial infarctions carry a significantly higher mortality. Perioperative myocardial in-

fraction rates as high as 21 percent to 36 percent have been reported in combined CABG surgery.²

One can assume that the risk of correcting two pathological processes during one operation might be greater than that of operating on individual isolated conditions, and this may well obtain in the case of concomitant peripheral vascular pathologic processes. However, in the case of valvular hemodynamic compromise or more tellingly in the case of complications from myocardial infarction, to omit correction of a secondary condition could jeopardize the outcome of the repair of the primary condition. For this reason, in those properly selected patients, combined correction should lower the risk factors in patients in whom two different pathological conditions exist.

This report reviews our experience with the operative treatment of this group of patients requiring CABG surgery combined with other cardiovascular operative interventions.

MATERIALS AND METHODS

From September, 1976 to August, 1983, 55 patients underwent CABG surgery combined with either aortic valve replacement, mitral valve replacement, ventricular aneurysm repair, ascending aortic aneurysm repair, post-infarction ventricular septal defect repair, or simultaneous carotid endarterectomy (Table III). There were 46 males and nine females with a mean age of 64

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years, ranging from 40 years to 76 years of age. Nine patients underwent emergency operation, four with preinfarction angina and five in cardiogenic shock. Six patients had critical left main occlusive disease. Sixty-one percent of the patients had unstable angina and 33 percent of them had overt symptoms of congestive heart failure. Six patients had acute infarction (Table I). Six patients further had suggestive signs or symptoms of critical carotid stenosis. The preoperative electrocardiogram was abnormal in over 90 percent of the patients, including 51 percent of the patients with demonstrated Q waves. Severe compromise of the myocardium could be inferred in patients as evidenced by 18 percent of the patients having ejection fractions below 40 percent, and 62 percent demonstrating segmental dyskinetic abnormalities. Four patients required preoperative intraaortic balloon pump (IABP) support (Table II).

Table I
CLINICAL CHARACTERISTICS OF 55 PATIENTS
UNDERGOING COMBINED CORONARY ARTERY
BYPASS SURGERY

Baseline Data:

Mean Age (yrs)	64
Males (%)	83
Females (%)	17
Unstable Angina (%)	61
Congestive Failure (%)	33
Acute Infarct (%)	11
Vascular Disease (%)	18
Emergency Intervention (%)	16

Table II
LAB AND CATHETERIZATION CHARACTERISTICS
OF 55 PATIENTS UNDERGOING COMBINED
CORONARY ARTERY BYPASS SURGERY

Parameters:

E. F. < 40 (%)	18
Preop EKG Abnormal (%)	91
EKG With Q Waves (%)	51
Hypokinesis/Akinesis (%)	62
Preop IABP (%)	7
Left Main Obstruction (%)	11

Twenty-five patients underwent aortic valve replacement at the same time as coronary artery bypass grafts and six patients underwent mitral valve replacement concomitantly. In 14 patients a ventricular aneurysm was resected along with coronary artery bypass surgery. Three patients had coronary surgery in conjunction with repair

Table III
COMBINED CORONARY ARTERY BYPASS SURGERY
1976-83

Operations:

CABG + Aortic Valve Replacement	25
CABG + Ventricular Aneurysm Resection	14
CABG + Carotid Endarterectomy	6
CABG + Ventricular Septal Defect Closure	3
CABG + Ascending Aortic Aneurysm Repair	1
CABG + Mitral Valve Replacement	6
TOTAL	55

of a post-infarction ventricular septal defect. One patient had simultaneous repair of a large ascending aortic aneurysm and six patients had carotid endarterectomy simultaneously performed with their bypass operation because of critical stenosis. Two patients represented reoperation cases, one for progression of coronary occlusive disease, graft occlusions and development of a ventricular aneurysm; the other for prosthetic bacterial endocarditis. One hundred and forty-two grafts were performed for an average of 2.58 grafts per patient.

All operations were performed using cardiopulmonary bypass. Protection of the myocardium has taken an increasing importance and consists of core cooling to moderate hypothermia (26° C. to 30° C.), cold potassium cardioplegia, topical well-type cooling, and monitoring of myocardial septal temperatures. Reoperation patients were cannulated through the femoral artery, however, all other patients had proximal aortic cannulation employed. For carotid endarterectomy, the carotid incision was performed simultaneously with median sternotomy including entry into the pericardium. Purse string sutures were placed in the usual manner and the patient systemically totally heparinized. At this time, an option could be exercised to proceed to cannulation immediately prior to, or following endarterectomy, depending on the individual patient requirements. No carotid intra-luminal shunts were used. During aortic valve replacement, the left coronary ostium was cannulated for perfusion with cold cardioplegic solution.

RESULTS

Among the 55 patients studied, there were 50 survivors and five hospital deaths for a perioperative mortality of nine percent. Excluding emergency or rescue operations in three patients, the perioperative mortality was 3.6 percent. Only one

CORONARY BYPASS SURGERY

death occurred among elective, first operation patients for a perioperative mortality of 1.9 percent (Table IV). Four patients required preoperative IABP support. One patient was a long-term survivor. Four patients required postoperative IABP support. The mortality rate was 50 percent, indicating that IABP is a poor prognostic indicator. A total of nine patients were operated upon as emergency cases, including two patients with ruptured mitral papillary muscles and three patients with post-infarction ventricular septal defect who were in cardiogenic shock. Four patients had unstable pre-infarction angina.

The efficacy of myocardial preservation is often gauged by the perioperative occurrence of myocardial infarction.³ Criteria used to that effect have included enzyme profiles, electrocardiographic changes, and radionuclide scans. No survivors showed signs of unequivocal perioperative infarction, however, in the total group, several patients had preoperative indications of recent or remote infarction which made the application of selection criteria difficult. Two early survivors, one of which had an evolving infarct and ruptured papillary apparatus had unequivocal evidence of infarction and subsequently succumbed. Thus, the incidence of perioperative

myocardial infarction is judged to be no higher than 3.6 percent for the entire group.

Thirty patients had early as well as late complications of varying degrees (Table V). Exclusive of the group with ventricular power failure which led to the five hospital deaths, there were five patients with early complications whose discharge was actually delayed because of these complications.

Five patients succumbed in the course of their illness and an analysis of the associated circumstances is listed in Table VI. Of note is a 64-year-old male who underwent four-vessel revascularization and ventricular aneurysm resection having undergone coronary artery surgery nine years previously. There was a period of instability immediately preceding cardiopulmonary bypass possibly related to his eventual fatal outcome.

DISCUSSION

This group of patients represents a particularly high risk category due to the cumulative effects of the various pathological processes present at the time of intervention. In the preoperative setting, both the short-term and long-term outlook in this

Table IV
RESULTS OF COMBINED CORONARY ARTERY BYPASS SURGERY

	<i>Patients</i>	<i>Emergency</i>	<i>Pre-IABP</i>	<i>Post-IABP</i>	<i>Enzymes +</i>	<i>EKG +</i>	<i>Death</i>
CABG + AVR	25	1		1	2 (4)	1	1
CABG + V. A.	14	1		2	3 (2)		1
CABG + CEA	6	2	1	1			
CABG + VSD	3	3	1				1
CABG + AscA	1						
CABG + MVR	6	2	2		(1)	1	2
Grafts/Patient	2.58						
Coronary Endarterectomy	11						
% Patients		16	7	7	9	3.6	9/3.8/1.9

Table V
COMPLICATIONS FOLLOWING COMBINED CORONARY
ARTERY BYPASS SURGERY

<i>Early Complications</i>		<i>Late Complications</i>	
Harvest Site Healing	1	Residual VSD	1
Reoperation for Bleeding	3	Cerebrovascular Accident	1
LVPF (Ventricular Power Failure)	6	Permanent Pacemaker	2
Leg Ischemia	1	Hepatitis	1
Respiratory Insufficiency	3	SBE	1
Visual Defect	1	Reoperation	2
Peripheral Nerve Deficit	2	Colon Polyp	1
Central Neurologic Deficit	2	Congestive Failure	1
Sternal Dehiscence	1		
Renal Insufficiency	1		

CORONARY BYPASS SURGERY

Table VI
ANALYSIS 5 FATAL RESULTS COMBINED CORONARY ARTERY BYPASS SURGERY

<i>Procedure</i>	<i>Patients</i>	<i>Emergency</i>	<i>Reoperation</i>	<i>Associated Circumstance</i>
CABG + V.A.	1		1	Reop — LVPF — Post IABP
CABG + MVR	2	2		E — OMI + AMI — Pre IABP — LVPF
CABG + AVR	1			E — AMI — Pre IABP — LVPF
CABG + VSD	1	1		150 mm Hg Grad — IABP
				E — AMI — Pre — IABP — Vent. Volume
Total Survival	9%	3.8%	1.9%	

LVPF — left ventricular power failure
Post IABP — post operative intra-aortic balloon
Pre IABP — preoperative intra-aortic balloon
E — emergency
OMI — old myocardial infarct
AMI — acute myocardial infarct

group of patients is quite grim and even in those in whom there is not an immediate proximity of death, a high later mortality is expected. Surgical intervention is thus indicated to save and prolong life.⁴

Advances in cardiac surgery, anesthesia, and perfusion technology have made it possible to offer a reasonable chance of survival to this extremely compromised group of patients. The safety of the procedure has been improved by (1) complete revascularization, (2) moderate body hypothermia, (3) excellent myocardial preservation. Even in the complex repairs when the clinical setting allows a first intervention and an elective choice, the safety of the operation approaches that attained in routine revascularization procedures.

SUMMARY

The presence of simultaneous multiple pathological processes in patients afflicted with the

ravages of atherosclerotic cardiovascular disease makes for a high risk group of surgical patients when it comes to reparative intervention. A retrospective study was undertaken to analyze the efficacy or safety of treatment in a group of 55 patients undergoing CABG surgery combined with aortic valve replacement, ventricular septal defect, mitral valve replacement, ascending aortic aneurysm resection and simultaneous carotid endarterectomy. There were 50 survivors and five hospital deaths. A first-time elective operation carried a mortality risk of 1.9 percent. □

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MULTIPLE PRIMARY CANCERS IN THE SAME PATIENT: CASE REPORTS AND A REVIEW OF THE LITERATURE

J. SIDNEY FULMER, M.D.*

JOHN M. FLEMING, M.D.

Multiple cancers occurring in the same patient can no longer be considered rare. Since Billroth first presented his cases, nearly 100 years ago, some 30,000 cases have been reported in various publications world-wide.¹ Most reports have been of simultaneous or sequential tumors of the same organ system. Less commonly reported have been those tumors involving more than one organ system. Reports of three or four distinct carcinomas have been rarer.²

For the practicing physician, however, awareness that a patient may have more than one primary malignancy, and that this is not some isolated freak of nature, becomes of increasing importance. Dr. William Cahan, in introductory remarks at the 1976 International Workshop on Multiple Primary Cancers, stated that such cancers are certainly a part of the overall oncologic problem, and can no longer be considered a fragment of the cancer experiment. That multiple primary cancers are actually increasing in frequency, Dr. Cahan reports, is attributable to better recognition by both pathologists and clinicians, in part to the myriads of carcinogenic forces engendered by our contemporary way of life, and indeed an ironic tribute to the better control of cancer, which enables between five and 10 percent of patients who survive their first cancer to live long enough to develop a second cancer at another site.³

Three cases of multiple primary malignancies are included in this report.

CASE REPORTS

Case #1 — L.D.M. — A 76-year-old white female who first presented for a "routine" gynecological examination. The patient gave a history of having had a left radical mastectomy four years pre-

viously for adenocarcinoma of the breast. Prior to that, at the age of 36, the patient had had her right ovary removed for a benign tumor but the exact pathological diagnosis could not be obtained.

The patient presented with no complaints but on pelvic exam was found to have a large mass (measuring 16 x 20 cm) arising from the pelvis.

The patient was admitted to the hospital for preliminary work-up and exploratory laparotomy. Chest film was negative. Barium enema showed diverticulosis of the sigmoid colon and on I.V.P. — in addition to the large pelvic mass, partially obstructing the right ureter — a mass was described in the left kidney. Renal ultrasonography showed a 3 cm cyst in the upper pole of the left kidney and the lower pole showed a solid renal mass suggestive of renal cell carcinoma. Bilateral selective renal angiography was highly suspicious of carcinoma of the left kidney involving the lower pole.

At surgery the large ovarian tumor was removed intact with pathological report showing well-differentiated papillary cystadenocarcinoma of the ovary. The left kidney was removed during the same operation with pathological report of renal cell adenocarcinoma. The renal cell carcinoma was a small lesion confined to the kidney without regional node spread.

Slides from this operation and from the previous breast surgery were reviewed and the pathologist reported that neither malignancy was related to the previous carcinoma of the breast.

Because of the possibility of seeding in the pelvis from the cystadenocarcinoma of the ovary, the patient received 5000 rads cobalt 60 teletherapy to the whole pelvis during a five-week span post-operatively.

The patient did well for approximately five months before she was seen in the emergency room with difficult breathing, nausea and vomiting and a hemoglobin of 5.1 and hematocrit of 15.7 percent. The patient was transfused and im-

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MULTIPLE PRIMARY CANCERS

proved. Upper G.I. series showed a small hiatal hernia, otherwise negative. A barium enema was negative except for diverticulosis, proctoscopic exam was negative. A chest film was also reported as negative.

Forty-eight hours after admission, the patient suddenly expired. An autopsy was not obtainable.

This patient's family history was significant in that several cousins had died of cancer but of unknown type.

Case #2 — W.G.H. — This patient is a 45-year-old white female who in 1954 had excision of a lesion of the third toe, left foot. Pathological report showed malignant melanoma and described both epidermal and dermal involvement with infiltration of the subcutaneous fibro-fatty tissue. Subsequently, the patient had amputation of toe of the left foot and left groin dissection, with report of one node positive for metastatic melanoma.

Following this surgery the patient did well, without any apparent problems until September, 1971 (some 12 years later) when on physical examination a mass was discovered in the upper outer quadrant of the left breast. From this same physical exam, a pap smear was reported as showing cells with severe dysplasia approaching *carcinoma-in-situ*. Excisional breast biopsy was positive for adenocarcinoma of the breast. A radical mastectomy was performed with lymph nodes negative for metastatic disease. Final pathological report was poorly differentiated adenocarcinoma of the breast.

Subsequent conization of the cervix revealed intraepithelial carcinoma of the cervix. Multiple sections of cervical tissue revealed fairly broad areas of severely dysplastic stratified epithelium with foci of full thickness differentiation but no demonstrated invasion. A total abdominal hysterectomy was performed with final pathological report showing mild to moderate epithelial dysplasia of the cervix with no residual *in-situ*.

In October of 1979, a 1 x .8 cm lesion on the right side of the patient's nose was removed with pathological report of a multifocal basal cell carcinoma, totally excised.

In July of 1982 a 3 x 2 cm firm nonfixed mass was discovered in the upper outer quadrant of the right breast. But subsequent excisional biopsy of the mass was benign — fibrocystic disease.

In August of 1982, an excisional biopsy of a 0.9

cm x 0.5 cm lesion of the right vulvar was done. Pathological report was *in-situ* squamous cell carcinoma of the vulva. The pathologist commented that this was an extensive multifocal process with the *in-situ* areas limited to the more central region of the lesion, but with variable degrees of dysplasia extending close to the surgical margins.

The patient's family history is significant in that her maternal grandmother and grandfather both died of stomach cancer. Two maternal aunts had cancer, but type is not known.

At present this patient is doing well.

Case #3 — A.B.H. — This patient is an 87-year-old white female who in March of 1958 (at the age of 63) had a diagnostic D & C for post-menopausal bleeding. A diagnosis of adenocarcinoma of the endometrium was made and the patient subsequently had a total abdominal hysterectomy and bilateral salpingo-oophorectomy.

The patient did well after this surgery and had no further problems until July of 1971 (some 13 years later) when she developed a mass in the left parotid area. A left parotidectomy was performed with pathological diagnosis of benign adenoma of the parotid gland.

In May of 1979, the patient had excision of a small lesion of the right eyebrow and a 2 x 1 cm lesion of the right lower leg. Pathological diagnosis of each lesion was poorly differentiated squamous cell carcinoma of the skin but not involving the margins of the excision.

In January of 1980, a 2 x 2 cm mass developed in the right parotid area. A right parotidectomy was performed with pathological diagnosis of mucoepidermoid carcinoma of the parotid gland.

In October of 1980, a lesion of the right hand was excised with pathological report of intraepithelial carcinoma of the skin.

In August of 1982, the patient was admitted to Spartanburg General Hospital for rectal bleeding. Barium enema was negative except for diverticuli. On proctoscopic exam an actively bleeding polyp was encountered at 10 cm. The polyp was excised and pathological report was benignadenomatous polyp.

At present, except for increasing senility, this patient is doing well.

Summary — Case #1

- (1) Adenocarcinoma of left breast — age 72.
- (2) Renal cell carcinoma left kidney — age 76.

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- (3) Papillary cystadenocarcinoma left ovary — age 76.

Summary — Case #2

- (1) Malignant melanoma third toe of left foot — age 22.
- (2) Adenocarcinoma of the left breast — age 34.
- (3) *Cancer-in-situ* of the cervix — age 34.
- (4) Basal cell carcinoma of the right side of nose — age 42.
- (5) *In-situ* squamous cell carcinoma of vulva — age 45.

Summary — Case #3

- (1) Adenocarcinoma of the uterus — age 53.
- (2) Mucoepidermoid carcinoma of right parotid gland — age 66.
- (3) Squamous cell carcinoma of the skin — age 74.
 - (A) right eyebrow
 - (B) right lower leg
- (4) Intraepithelial carcinoma of right hand — age 76.

DISCUSSION

In 1884, Billroth established criteria for diagnosis of multiple primary malignancies in the same patient (criteria which one investigator has called “too severe and typically Germanic”).⁴

These criteria stated that

- (1) Each tumor must have an independent histologic appearance.
- (2) The tumors must be separate and situated in different organs.
- (3) Each tumor must produce its own metastasis.

In 1932, believing that these criteria were indeed too strict, Warren and Gates modified them after having found 1,259 patients from the literature with reasonably well-documented multiple primary cancer.⁵

In their criteria

- (1) Each suspected tumor must be distinct and must be malignant.
- (2) The probability that one has a metastatic lesion from the other must be excluded.

Moertel *et al*, in a 10 year survey of 37,580 cancer patients at the Mayo Clinic found 1,909 patients or 5.1 percent with multiple primary

neoplasms. One thousand forty-nine of these patients or 2.8 percent of the surveyed population were found to have multiple malignancies of different tissue origins.⁶

Mersheimer and Ringer report an incidence of multiple primary malignancies of 3.2 percent. After analyzing the records of 140,000 cancer patients, they found 96 percent of the 3.2 percent with multiple cancers to have had two primary cancers, 4.5 percent had three primaries, and 0.5 percent had four or more.⁷

Schottenfeld in a review of 41,341 cancer patients treated at the Sloan-Kettering Institute from 1949-1962 reported that of 5,636 autopsies on cancer patients 176 (or 3.1 percent) had occult second primary cancers in different organs or tissues.⁸

Other necropsy studies have shown that between 5.3 and 8.1 percent of cancer patients have second primary cancers, either occult or clinically apparent, in different organs or tissue.⁹

IMPORTANT ASSOCIATIONS

In surveying the literature, many interesting and significant positive associations involving multiple primary cancers have been reported. These associations have raised the very important question of whether the existence of a specific type of cancer implies a predisposition to another specific type of cancer or to a group of cancers. If a woman develops breast cancer, does this predispose to uterine cancer or other genital cancers? These associations may aid the practicing physician to predict those patients at increased risk.

Schottenfeld and others in a study of over 40,000 cancer patients have established certain important associations in multiple cancers. For example:

- (1) breast, ovary, endometrium
- (2) large intestine, breast, female genital tract
- (3) leukemias, lymphomas, and skin.¹⁰

In a study by Berg and Schottenfeld of 9,792 women with breast cancer, ovarian cancer accounted for 10 percent of all new primaries.¹¹

In a 1963 study of patients in the Connecticut cancer registry, Bailar observed that females with endometrial cancer had a 1.5 times higher expectation of developing breast cancer.¹²

Schoenberg studied a similar population of females with breast cancer and found that the subsequent risk of a new primary cancer in the

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uterus or ovary was approximately doubled.¹³

Newell and Krementz, in a 23-year period (1948-1978) at Charity Hospital in New Orleans, reported that white and black women with initial breast cancer had an excess risk of developing cancers of the buccal cavity and pharynx and an additional breast cancer. White women with breast cancer had a slightly increased risk for developing cancer of the corpus uteri and leukemias in this series.¹⁴

One of the best documented associations has been between breast cancer and cancer of the corpus uteri, ovary, and colon in women. Since infertility or low fertility has been a factor associated with all four of these malignancies, this has provided a basis for further thought and investigation.¹⁵

Certain studies have suggested that a significant percentage of patients with a gynecologic malignancy will subsequently develop another genital malignancy. Also suggested is that patients with cervical cancer, because of their youth and retained genital organs, may be more likely to develop a subsequent malignancy.

Buchler, in a series from the University of Wisconsin of patients with cervical cancer, found that 41 percent developed their subsequent cancers more than 10 years after treatment, making continued observation beyond 10 years in these patients mandatory.¹⁶ The study also concluded that long-term follow-up should not be directed toward the pelvic area alone. As Nolan and others have also pointed out, concern must also be directed toward the breast and abdominal examinations and unusual complaints should not be ignored. As they have stated, "Even cancer phobes may develop cancer and succumb to it."

As important as these associations may be and the implications of risks, not all of these reviewed studies have been able to document certain of these reported associations.

For example, Berg has reported an increased risk of approximately eight-fold for women with a malignancy of the salivary gland of subsequently developing breast cancer.¹⁷ However, other investigators, including Moertel, have failed to substantiate this association.

Bailar and his associates have reported an increased incidence of oral cavity tumors in patients with uterine cancer. Studies by Schottenfeld and Berg have found no such increase.¹⁸

Schoenberg found a statistically significant

two-fold excess of rectal cancer following both cervical and corpus cancer,¹⁹ but studies by McMahon, Schottenfeld, and others have found no excess of colon cancer following either cervical or corpus cancer.²⁰

CLASSIFICATION OF MULTIPLE PRIMARY MALIGNANT NEOPLASMS

A classification of patients with multiple primary cancer has been presented by Moertel and his associates.²¹

- I. Multiple primary malignant neoplasms of multicentric origin —
 - (A) The same tissue and organ (for example, multiple epitheliomas of the skin)
 - (B) A common, contiguous tissue shared by different organs (for example, squamous cell carcinoma of pharynx and squamous cell carcinoma of larynx)
 - (C) Same tissue in bilaterally paired organs (for example, bilateral breast cancer).
- II. Multiple primary malignant neoplasms of different tissues or organs (example — adenocarcinoma of the breast and osteogenic sarcoma or squamous cell carcinoma of the mouth, squamous cell carcinoma of cervix).
- III. Multiple primary malignant neoplasms of multicentric origin plus a lesion(s) of a different tissue or organ. (Combines the first two.)

ETIOLOGICAL CONSIDERATIONS

In spite of many important contributions in the field of cancer research, the origin of cancer remains a mystery. Modes of cancer therapy, hormonal and hereditary influence have all come under careful scrutiny as possible etiologic factors in the development of multiple primary malignancies. To date there is no true evidence that the patterns of occurrence of these multiple primary malignancies are governed by anything more than coincidence.

In a recently reported retrospective 10-year study of 116 patients with multiple primary malignancies at M. D. Anderson Hospital, three oncogenic factors were considered:²²

- (1) That the immuno-suppressive effects of radiation and chemotherapy may render patients susceptible to develop other malignancies.
- (2) Anticancer agents can damage directly the cells producing mutagenic effects, and

- (3) The association of several factors (malnutrition, family history of cancer, viral infections, environmental factors, radiation) could also predispose to the "polycancerization syndrome."

Wynder *et al.* have hypothesized that dietary habits may be a common factor in increasing both colon and breast cancer.²³

That there may be a hormonal link between breast cancer and meningiomas has been suggested since, interestingly, meningiomas are the only intracranial neoplasms with a higher incidence in women, and an abrupt appearance of meningiomas during pregnancy is reported.²⁴

Newell and Kremenz have reported an excess risk of developing cancers of the oral cavity, lung and bladder following cervical cancer. This high level of risk had not been previously suspected. Since excess cigarette smoking has been reported among women who develop cervical cancer, Kremenz feels that it is interesting to speculate that cigarette smoking could account for these observed increases.²⁵

It is known that medical, surgical and X-ray methods of treating cancer are capable of producing profound changes in the neoplasm being attacked.

Steward and Treves (in 1948) reported the occurrence of lymphangiosarcoma in chronic lymph stasis. All of their reported cases developed at the site of lymphadema after radical excision of carcinoma of the breast.²⁶

Babcock has reported an uncommon tumor-peritoneal mesothelioma — originating in the right lower quadrant seven years after internal and external radiation for carcinoma of the cervix. Cases have been reported in the surgical literature of radiation-induced carcinoma of the rectum as a late complication of pelvic irradiation.²⁷

Both normal and abnormal cells are affected by chemotherapeutic agents. Penn has reported 166 new cancers in 160 patients treated with chemotherapy. The most common types were leukemias, solid lymphomas, and carcinoma of the urinary bladder.²⁸

In the previously-mentioned M. D. Anderson retrospective study, however, it was concluded that while certain modes of cancer therapy could render a patient more susceptible to develop a second neoplasm, the use of anticancer treatment cannot be suppressed in fear of the increased risk of developing a second tumor.

Vora has reported that nothing about cancer has been more accepted than its hereditary nature, but nothing is less satisfactorily proven. Although hereditary factors have been evident in the genesis of malignant neoplasms in experimental animals, there is little factual information to support the concept that such factors have an influence in man.²⁹

Moertel performed a retrospective study to assess the influence of heredity in multiple primary cancers. He found that when the occurrence rate of cancer was determined for all family members, the rate for members of the families with single cancers did not differ significantly from that of families without cancer. However, members of the families of patients with multiple cancer showed a 26 percent increase in the incidence of cancer over that found in members of the families of patients without cancer.³⁰

But Berg and Schottenfeld have reported in their series of multiple primary cancers at Memorial Hospital (1949-1962) that they uncovered no convincing examples of cancer families even with extra attention to patients with three or four or more primaries.³¹

SUMMARY

In summary, while multiple primary cancers in a single patient can no longer be considered a rarity, case reports such as those presented here do continue to appear and re-emphasize for the practicing physician that by increasing surveillance there will be a continuing increased frequency of cancer detection, diagnosis, and reporting.

The literature has provided some significant associations, many more contradictions and unproven hypotheses, and many inherent warnings. Too many of the studies have included very small samples to reach very broad conclusions. Factors such as heredity have been difficult to analyze due to poor recording in the first place.

And seemingly important correlations in one study have not necessarily been borne out in another.

But most cancer patients, as the M. D. Anderson study points out, do seemingly have increased risks for specific later cancers, depending on their original cancer types, and knowledge of these risks is of true clinical importance. □

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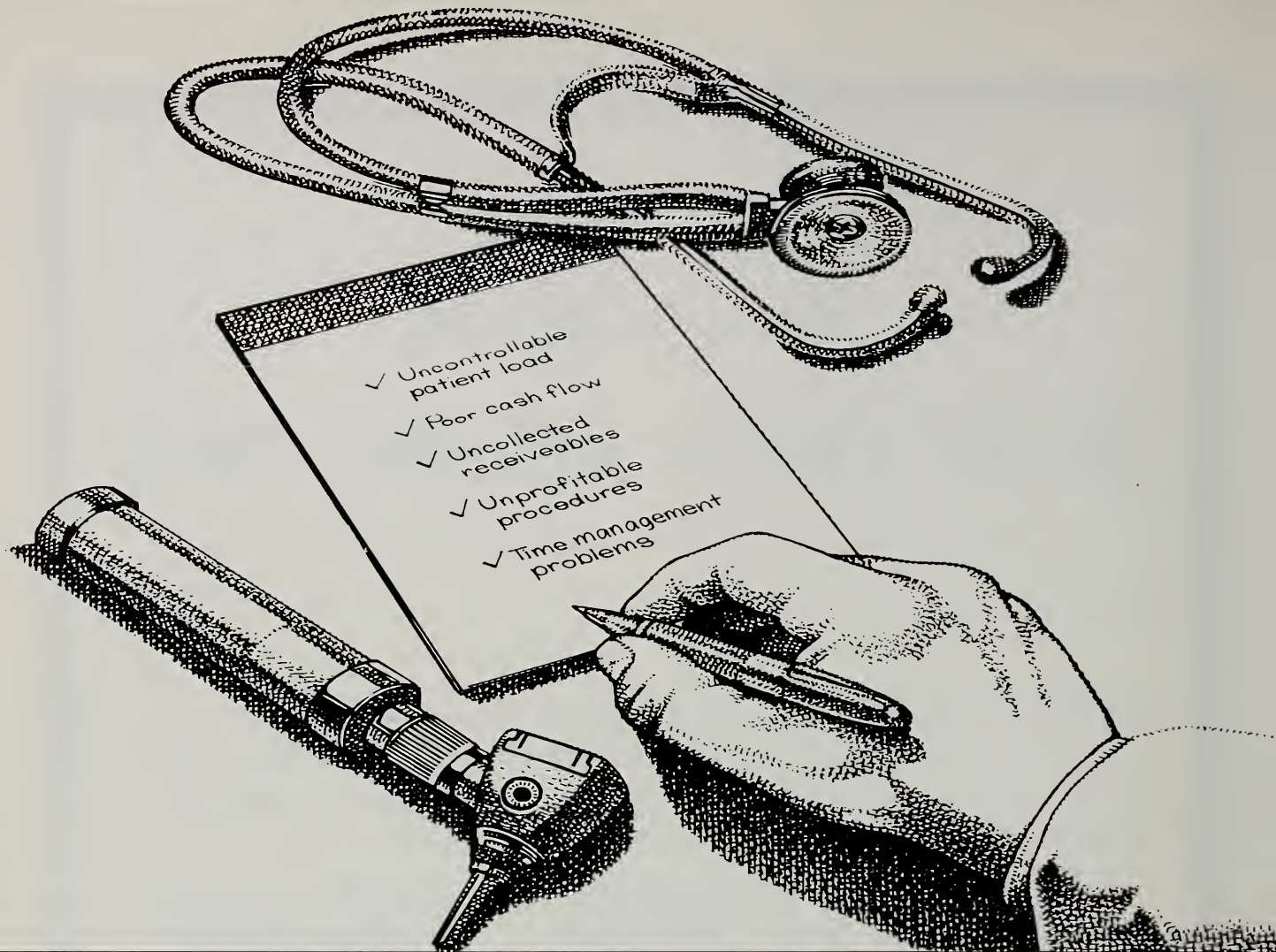
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UNCERTAINTY IN PROJECTING ACUTE CARE BED NEED IN SOUTH CAROLINA

SAMUEL L. BAKER*

The certificate of need (CON) remains a major vehicle for state regulation of hospital construction and renovation. The requirement that new or expanding hospitals obtain CONs prior to the start of any large project determines over time what facilities will be available to physicians and their patients. In South Carolina, CON applications for adding acute care beds are evaluated against bed need projections made by the Division of Medical Facilities Planning of the State Department of Health and Environmental Control (DHEC). This paper examines the methodology used to make these projections. The projections are found to be quite sensitive to random year-to-year changes in hospital bed usage rates and population estimates. They are also markedly affected by apparently minor changes in methodology.

DHEC calculates future need for acute care beds for each county individually, except for some counties deemed to constitute a market area. Table I shows how this was done for Richland County. As of 1984, the Richland hospitals' market is taken to be all of Richland County plus one-half of Lexington County. To save space, Table I gives detailed figures only for Richland Memorial Hospital.

DHEC projects into the future on the basis of a single year's bed usage. Because of lags in the availability of data from hospitals, that single year is two years before the date of the plan. In Table I, Actual Patient Days is what each hospital reported to DHEC for 1982. Adjusted Patient Days, a reform newly introduced in 1984, is an estimate of what patient days would have been if 30 percent of surgery were outpatient. (For the details of the methodology, see the 1984 State Health Plan, pp. II-8,9.) The adjustment reduces patient days by about 1.6 percent in Richland County. Adjusted Average Daily Census is Adjusted Patient Days divided by 365 days/year.

For the bed demand projection the 1982 Adjusted Average Daily Census by age group is increased by the projected population growth for that age group. Summing across the three age groups gives the projected average daily census for each hospital.

The projected average daily census is divided by a target occupancy rate, 75 percent for rural hospitals, 80 percent for small urban hospitals, and 85 percent for large urban hospitals. This step is the sole reason that separate calculations are made for each hospital, so that the target occupancy rate specific to that hospital can be used as divisor.

The quotient of bed demand divided by target occupancy rate is the projected future bed need. Summing over all the hospitals gives the total number of beds that need to be added by the projection date, here 41 for Richland County. Acute care beds in institutions with restricted public access, such as the University's Thomson Student Health Center, the Moncrief Army Hospital, and the Dorn Veterans' Hospital, are essentially ignored in these calculations. Though bed needs are shown for individual hospitals, in no sense do these beds "belong" to the particular hospital. Any institution, existing or new to the county, may be granted a certificate of need for the beds to be added.

This bed need estimate is dependent upon several numbers, each of which is subject to uncertain variation from year to year. Hospital utilization can vary due to changes in morbidity patterns, changes in medical practice, movements of medical staff, and changes in financial arrangements. Future population growth estimates also change. Even current population figures are only estimates based on incomplete data. As more data become available from federal and state sources, current population estimates change, as do future projections. All these combine to produce uncertain change in the number of beds that the formula says need to be added in a locality. Health

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ACUTE CARE BED NEED

Table I
BED NEED FOR 1988, RICHLAND COUNTY
South Carolina DHEC method, based on 1982 usage
Adapted from the 1984 State Health Plan

Population (includes one-half of Lexington County population.)

	1982		1988 Increase	
under 15 years old	74,427		75,257	1.12%
15-64	233,230		265,777	13.95%
over 64	27,599		33,688	22.06%

<i>Hospital</i>	<i>Actual Patient -days 1982</i>	<i>Adjusted Patient -days 1982</i>	<i>Adjusted Avg. Daily Census 1982</i>	<i>Projected Avg. Daily Census 1988</i>	<i>Target Occu-pancy Rate</i>	<i>Bed Need 1988</i>	<i>Actual beds 1983</i>	<i>To Be Added</i>
Richland Memorial								
under 15	12,754	12,506	34.26	34.65				
15-64	98,734	96,514	264.42	301.32				
over 64	46,956	46,908	128.52	156.87				
sum over all ages				492.84	÷ .85 =	580	579	1
Providence				176.51	÷ .80 =	221	239	-18
Baptist Medical Center				406.13	÷ .85 =	478	420	58
Restricted public access beds (Thomson, Moncrief, VA)						305	305	
					Total	1,584	1,543	41

NOTE: The presentation in Table I is not identical to that of Part II of the State Health Plan, but it is mathematically equivalent.

planners find themselves shooting at moving targets.

THE POPULATION ESTIMATES

The population figures reported in the State Health Plan are estimates. This is as true of the figures for the current year as it is true of the figures for the future year. The State Budget and Control Board Division of Research and Statistical Services directly estimates population by county only for decennial years. Other years are interpolated. Thus, for example, the figures in the 1984 plan for 1982 and 1988 were interpolated from the most recent estimates for 1980 and projections for 1990.

Every year the estimates for the decennial years, past and future, are modified to reflect results newly available from the prior decennial census, late trends in birth and death rates, and new estimates of migration patterns. As the decennial year estimates change, the interpolated estimates for in-between years change as well, which makes projected growth rates change. As Table II shows, the projected growth rate of the number of elderly has generally been rising, matched by a fall in the projected growth rate in the number of children. This shift in projected growth to the high-usage elderly population im-

plies that recent state health plans are showing a greater future need for beds, holding other factors constant.

USAGE RATE VARIATIONS

Bed usage is necessarily subject to variation from year to year which cannot be fully anticipated. Because bed demand is projected from one year's usage, usage variations translate directly into projected need variations. Thus in the usage rate fraction, bed-days per year divided by estimated population, both the numerator and the denominator vary.

As the entries on the diagonal in Table III show, a review of past plans would give the impression of a sharp decline in usage from 1979 to 1980, and again from 1981 to 1982. Consistent population

Table II
PROJECTED ANNUAL RATES OF POPULATION GROWTH BY AGE CATEGORY IMPLICIT IN STATE HEALTH PLANS 1981-1984

	<i>State Health Plan of</i>			
<i>Ages</i>	<i>1981</i>	<i>1982</i>	<i>1983</i>	<i>1984</i>
0-14	1.47%	1.73%	.48%	.50%
15-64	2.44%	2.31%	2.47%	2.45%
65+	2.74%	3.20%	3.77%	3.70%
all	2.22%	2.24%	2.14%	2.13%

Table III
ACUTE CARE HOSPITAL BED USAGE RATES,
PATIENT-DAYS PER YEAR PER 1,000
POPULATION, RICHLAND AND LEXINGTON
COUNTIES, ALL HOSPITALS COMBINED.
ENTRIES ACROSS ROW USE CONSISTENT
POPULATION ESTIMATES. ENTRIES ON THE
DIAGONAL ARE FIGURES PUBLISHED IN
THE RESPECTIVE STATE HEALTH PLANS,
EXCEPT AS NOTED BELOW.

Population Estimate from	Age Group	1979	1980*	1981	1982
1981 plan	0-14	296			
	15-64	1,025			
	65+	4,556			
	all	1,097			
1982 plan	0-14		250		
	15-64		974		
	65+		4,636		
	all		1,056		
1983 plan	0-14			245	
	15-64			950	
	65+			4,326	
	all			1,055	
1984 plan	0-14	300	263	244	241
	15-64	954	964	943	915
	65+	4,086	4,213	4,281	4,303
	all	1,040	1,054	1,047	1,036

*NOTE: Modified usage data for 1980. Baptist and Providence Hospitals underreported usage in some age groups and overreported usage in others for the 1982 State Health Plan. For 1980, patient-days were redistributed among age groups according to suggestions by officials of the two hospitals. The DHEC formula is not very sensitive to this sort of error, so long as the total usage for all age groups is accurately reported.

estimates reveal that there was little trend on usage over the period. Reading horizontally shows that usage actually rose from 1979 to 1980, then diminished in 1981 and 1982, finishing only slightly lower in 1982 than it had been in 1979. For the 65-and-over age group, the usage rate marched upward over 1979-82, though figures gleaned from the plans would indicate a drop.

This demonstrates the importance of using consistent population estimates in any analysis of usage rates. There has been much discussion of declining hospital usage. These figures suggest that though usage rates for persons under 65 have fallen, the rise in usage among persons over 65, the fastest growing segment of the state's population, may mitigate any tendency for shrinkage of overall hospital bed demand. Hopefully data coming available for 1983 will help clarify the direction of the trend.

THE DYNAMICS OF THE BED NEED PROJECTION

The effects of the various causes of change in the bed need projection can be roughly separated by making one change at a time and tracking the resultant change in the bed need projection. The separation is not perfect because the population interpolation and extrapolation are not linear. Thus it matters in what order one makes the changes. However, because of the short time period involved, the imperfection is on the order of one or two beds, which is small enough to be ignored.

Table IV presents the results of a stepwise analysis for 1981 through 1984. Richland and Lexington counties are used as the example. The relatively small changes in usage rates and population estimates and projections shown in Tables II and III translate into relatively large changes in the number of beds to be added. A small, say two percent, drop in the usage rate will reduce the projected total need by about the same two percent, an apparently negligible change. However, when one subtracts the current number of beds from the total need, that two percent translates into a 20 percent drop in the number of beds that need to be added. To cite a case in which this might have been important, in 1982 Humana, Inc., and Hospital Corporation of America each applied for a certificate of need to build a free standing 88-bed hospital in Richland County. To some observers, 88 beds seemed barely minimal for consistency with efficient allocation of health care resources. If the usage rate had not jumped in 1982 compared with 1981 and 1983, the 1982 State Health Plan would have shown a need for only 72 beds in the area. This need figure might have been small enough to have discouraged a certificate of need application for a new hospital.

The effect of the outpatient surgery adjustment also shows how highly sensitive the projection is to small changes in usage rates. Adjusted usage rates are only 1.7 percent and 2.7 percent less than actual rates in Richland and Lexington counties respectively, but the effect on beds to be added is about ten times as great as these percentages.

SUMMARY AND RECOMMENDATIONS

Two approaches should be explored to reducing the uncertainty in bed need projections. Future usage rates should be projected on the basis of several years' experience, not just one. The relia-

ACUTE CARE BED NEED

Table IV
CAUSES OF YEAR-TO-YEAR CHANGE IN ACUTE CARE BED NEED PROJECTIONS, RICHLAND AND LEXINGTON COUNTIES, SOUTH CAROLINA STATE HEALTH PLANS, 1981-1984

A. Richland and Lexington Counties Combined as in State Health Plans 1981-83

Change from Plan of: to:	Beds to Add in Earlier Plan°	Changed Population Estimates	Changed Usage Rates	One Year's Population Growth	Beds Authorized in Year (subtracted)
1981 1982	90	9	13	40	-64
1982 1983	88	22	-15	45	0
1983 1984	140	-4	-31	[46]	0
Average Absolute Value of Change		11.7	19.6	43.7	
Relative to Average Beds to be Added		12%	20%	44%	

B. Separating the Counties, 1984 methodology. (Note: A 1984 change in a rounding convention subtracted two beds from total need.)

Beds to be added (change)			Remarks
Total	Richland	Lexington	
105	61	44	Splitting counties added 2 beds to total need.
75	40 (-21)	35 (-9)	Outpatient surgery adjustment. Corresponds to 1984 Plan.
[121]	73 (+33)	49 (+14)	If 5-year projection had been used]

bility of the population estimates should be improved. Physicians, hospital administrators, and health planners have an interest in supporting efforts to enhance the ability of the Division of Research and Statistical Services to acquire timely relevant data, such as from tax returns now closed to it. These steps would improve the consistency and reliability of the bed need projections, reducing the likelihood of surprises that might disrupt hospital planning efforts.

Three reforms of the bed need projection formula that were implemented in 1984 deserve comment with regard to their impact on Richland and Lexington counties. Shortening the time horizon for projections from five years to four in effect put off 46 beds for one year. Separating the two counties eliminated the possibility that a new free standing hospital can be granted a CON in accordance with the State Health Plan for the near future. The number of beds available in one county alone is simply too small. In general, separating counties favors existing institutions, while larger market areas favor new entrants. The outpatient surgery adjustment was DHEC's first formal effort to project based on something other than a snapshot of current usage rates. As such it represents progress, and will surely be improved in the future.

Finally, because the shortened time horizon and the outpatient surgery adjustment reduce the bed need, they increase the relative importance of

the uncertainty that usage rate and population estimate variations introduce into the bed need projections. Though there may be legal and political obstacles to altering the Division's projection method, the case for developing a more sophisticated statistical model of usage and for obtaining better estimates of population is becoming even more compelling.

SUMMARY

Under the current methodology, acute care bed need projections for South Carolina counties are subject to considerable uncertain variation from year to year. The main causes of the uncertainty are variations in usage rates and the population estimates. The uncertainty could be reduced if a statistically more satisfactory method could be devised for predicting usage rates, and if better population estimates were available. In this paper, the impact of 1984 methodological reforms is estimated, including the shortening of the planning time horizon from five years to four. For Richland County, for example, beds-to-be-added is reduced by 33. The outpatient surgery adjustment reduced bed need in Richland County by 21. □

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THE OPERATING ROOM: AN HISTORICAL PERSPECTIVE

BRENT V. STROMBERG, M.D.*

The modern twentieth century operating room has its beginnings in 16th century Italy and France. Prior to this era there is little mentioned of either operating room or amphitheatre in medical history. The first permanent operating theatre used predominantly for anatomical dissections is credited to Fabricius ab Aquapendente (1533 a.d.). It is said that he built his own amphitheatre in Padua at his own expense. It was in this same theatre a century later where Morgagni (1682-1771) did much of his work. It is evident from the historical description that the purpose of this amphitheatre, as well as others of this era, was for anatomical dissections and not for operations upon live patients. Indeed, the monumental work of Vesalius, the *Fabric of the Human Body*, (1543-1555) and its accompanying illustrations denote a public amphitheatre for anatomical dissection. These were meant for educational purposes, and in large part, for public entertainment. It can be postulated that little anatomic discovery was actually made in such locations. It is far more likely that Vesalius did his significant work in quieter surroundings. The expansion of such areas into France proceeded relatively quickly. By the late 17th century numerous amphitheatres had been built in France and Germany. The gradual extension of their usage to include live operations was slow however. From France came numerous barber surgeons who made significant contributions. LaFranc (1315), Pierre Franco (1500-1561), Ambroise Pare (1510-1590), and Charles Felix were a few of the surgeons who provided significant contributions to the instruction of anatomy and the care of surgical problems in the latter half of the century.

A significant controversy existed for generations between the faculty of medicine in the various locations and the surgeons. The physicians

claimed their knowledge rested upon book learning and felt that practical experience was unnecessary. The barber surgeons held the opposite view, that practical experience was all important and book learning was of little value. As a consequence, through the years surgeons at the Faculty of Medicine in Paris were required to take an oath acknowledging that medicine was always better than surgery. This humiliating requirement was maintained until the mid-18th century. The beginning of the demise of the humiliation of the surgeons was with the success of Charles Felix of Paris in operating upon the rectal fistula of Louis XIV^{1, 2, 3}. By royal decree, barber surgeons were then given advanced standing. They were given the privilege of dissecting cadavers as well as treating open wounds. Shortly after this, a large amphitheatre was constructed at St. Come for operating and public lectures. This had a seating capacity for more than a hundred individuals. It was constructed in 1694 and eventually became the center of the Royal Academy of Surgery of France. This increased favor resulted in significant contention between the physicians and surgeons of the day. Nevertheless, the surgeons had a strong foothold now with the approval of the royalty of France and the barber surgeons increased their power.

It should be emphasized that despite this newfound respectability, almost all actual surgical procedures were still performed at the patient's bedside. The amphitheatres were used predominantly for public lecture and anatomical dissection. In the 18th century, the increasing skill in surgical anatomy and dexterity of the surgeons fostered a desire among surgeons to be seen by more of the public. More and more operations were brought into the amphitheatres in an attempt to spread the fame of individual surgeons. The surgical amphitheatre grew in size and ornateness. Often constructed adjacent to large public areas and marketplaces, surgery became a

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THE OPERATING ROOM

public event. Certainly with the lack of anesthesia and understanding of good hemostasis, each operation had a significant morbid drama to it.

The swiftness and dexterity of the operating surgeon became his advertisement and claim to fame. As the means of attracting patients and spreading their influence in the preanesthesia era, surgeons would openly advertise their speed at doing various operations. An account of an operation for a gluteal aneurysm in 1860 by the great surgeon Syme relates that 800 spectators observed the operation. A large applause both preceded and followed the surgery.⁴ The entire operation had lasted a matter of minutes.

Another recollection of a famous surgeon was that of Lister. His first operation using ether anesthesia was in 1846 before a large number of visitors at the amphitheatre at Guy's Hospital. The operation was an amputation of the leg. As a matter of technique, Lister did the entire procedure, from first incision to final ligature in less than five minutes.⁵

Evolution in surgical thinking is represented best in the German universities. It was there that chairs of surgery were first created. It was considered, at that time, beneath the dignity of those who taught surgery to actually perform it. Thus Haller (1708-1777) who was a professor of surgery at Goettingen and Berne, never was known to have performed an operation himself. It was not until a century later that this philosophy would be permanently changed.⁶

It was said that pain, hemorrhage, and infection were the three great evils which had limited progress in the practice of surgery. In the late 1800's, all three were dramatically changed by the discovery of anesthesia and asepsis. These two discoveries permitted careful surgical technique and hemostasis⁷; a new era had dawned. In addition, this marked the end of the surgical amphitheatre as a place of public display and surgical instruction.

Discovery and routine use of anesthesia increased the volume of surgery geometrically. The statistics from the Massachusetts General Hospital regarding the volume of surgery before and after the introduction of anesthesia are informative. In the ten years preceding the introduction of anesthesia, fewer than 40 operations were performed per year. In the ten years following the introduction of ether anesthesia, an average of 190 cases were recorded per year; a four and one-half fold

increase. In the next 40 years, this number would swell to greater than 3,000 operations per year, within this one institution. Similar statistics were reported from other hospitals of this era.⁸ At the end of the 19th century, elegant new operating rooms were being constructed. In 1895, the Middlesex Hospital constructed a new operating area with teakwood benches for 130 students, teak staircases and a marble floor.⁹

The dramatic change of the size of the audience was brought as a direct consequence to advances in antisepsis. The monumental labor of Pasteur and the realization of its importance by Lister marked the end of surgery as a public spectacle. Lister's contribution rests predominantly in his appreciation of the practical application of Pasteur's work. In 1867, Lister made his clear contribution with the reduction of wound infections with carbolic acid. That it took a generation of surgeons to accept these principles is a tribute to stubbornness. The tenets of Pasteur and Lister implied that a limitation should be placed upon the number of spectators within the operating room. For a while this was ignored. At the large meeting of the Clinical Congress of the American College of Surgeons in Chicago in 1913, large operating clinics were still utilized for instruction.¹⁰

The numerous advances in asepsis and antisepsis afforded new emphasis upon the attire of the surgical team as well as sterility of instruments and surroundings. Each of these areas, as well as associated areas of the development of surgical gloves, masks, air flow systems, wound and skin preparations, and antibiotics have all altered the drama and flair of the operating room. However, it has been this conversion of the large operating amphitheatre of history to the modern sterile operating room with good anesthesia that allows meticulous surgical technique which has increased dramatically the effectiveness and science of surgery. What we consider to be a modern operating room today can be expected to evolve significantly in the coming years.

SUMMARY

The operating room as an integral part of the hospital involved in patient care and teaching has undergone a dramatic evolution through the centuries. Formerly designed as a large surgical amphitheatre with much emphasis on instruction of

THE OPERATING ROOM

Anatomy and entertainment, an evolution in its purpose and form has occurred in relatively recent times. Fostered by the principles of advances in surgical technique, hemostasis, antisepsis, and anesthesia, the drama of surgery has decreased. At the same time the emphasis upon changing patterns of education and instruction of surgery has demanded a different format of surgical education. A brief outline in this evolution of the operating room is presented. □

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Editorials

Following is the sixth in a series of articles on medical education in South Carolina. Guest editorials reflect the opinions of the authors and do not necessarily reflect the policy of the Editorial Board and the South Carolina Medical Association.

— CSB

MEDICAL STUDENT, MEDICAL STUDENT; WHERE ART THOU?

The study of history provides an outlook on change which includes an appreciation for the flow and relationship of events. There has been an accelerating pace of change and a proliferation of inter-relating factors which impinge upon events throughout history. Further, the perspective required for sharp insight and understanding has been achieved infrequently by those who are contemporary observers or participants in change. These circumstances have created relentless pressures upon people, institutions and society, often generating insecurity and instability. A frequently observed response has been the return to basic values. Students and patients have taken the lead for such a response in medical education and medicine.

Medical education and the practice of medicine are inseparable. Change in one of these components invariably influences the other. My comments relate primarily to medical education but keep in mind that changes have been concurrently underway for the practice of medicine as well.

The traditional concept in academic medicine of the "three legged stool" consisting of teaching, research and service has provided balance for vitality, capital development and progress. This discussion will focus upon how change has influenced the relationship between these basic functions within the medical school.

The demands of scientific research have led to dedicated efforts by a nationally and internationally oriented faculty. Scientists have responded to a competitive environment. Within this environment graduate students or post-doctoral fellows who are more involved in research activities are often the recipients of the faculty's primary teaching efforts while the education of

medical students may be perceived to be on a lower priority.

There is little doubt that subspecialization, Medicare and Medicaid, faculty salary expectations, service to referring physicians and the medical center dependency on clinical income have been rewriting the teaching agenda of the clinical faculty. The clinical environment brings focus upon the patients. Because of their intense involvement in the care of patients, residents are the recipients of the clinical faculty's primary attention. As a result, medical students are frequently secondary recipients of the faculty's clinical instruction. Also, rapid technological development and its application narrows the view of patient care and precludes a holistic approach to patients for medical students. Students are aware of this problem in clinical education and have expressed their concern.

Task dedicated faculty, a highly competitive research environment and specialty oriented medicine have created a subdivided and highly structured medical school. In turn, this organization has generated an internal political environment with built-in conflict in securing recognition and resources. Further, the attention and energies of institutional leadership have been effectively channeled by the medical school concept of administration to serve the faculty, the focus upon influencing political and regulatory processes at all governmental levels, and the emphasis upon raising funds for all institutional purposes. The development of entrenched special interests among the faculty has been a force to sustain the status quo. Within this framework, teaching has not been a special interest but instead has served as an almost mystical background activity utilized by each interest group to justify its support in the

medical school.

Collectively, these concerns have attracted national attention. In response, a report recommending changes in the general professional education of physicians has been published. This published report reaffirms the basic principle that a strong educational base is built one layer at a time from the ground up. At the same time, we have recognized that the educational process requires as much dedication as does research or clinical care and none of these activities can exist successfully in isolation.

The medical school environment requires a value system which is basic to all dedicated interests. This value system must contain the precepts that the institutions' primary activity is education, its primary focus is the medical student, its primary outcome, a quality physician and the primary institutional mission is service. The productivity of medical education should be measured in the capability of our graduates, not in the number. Capable physicians are oriented to peo-

ple and service, they have a highly developed sense of inquiry and they are prepared to pursue their education over the span of their careers.

The medical school can best serve its purpose by identifying the basics and doing them well. Every effort should be made to select bright students who have acquired a liberal arts education with good value systems. The medical school should have a clear concept of the basic education of a medical student which includes clinical problem solving and self learning. The faculty should establish and maintain clear academic standards for medical students. Above all, effective professional education should be based upon teachers whose principal aim is *to stimulate students to learn*.

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AN ALTERNATIVE TO CAPITAL PUNISHMENT

About 2,400 years ago, Socrates was found guilty of crimes against the polis (i.e. state) and was sentenced to either exile or ingestion of a cup of hemlock. Socrates' description of his death, as recorded by Plato, makes for intriguing reading. For the physician, it's interesting to speculate on the physiology of his death. He describes the paresthesias of his lower extremities that gradually ascended until he died a very easy death. Prior to his drinking the hemlock, Plato quotes Socrates as saying, "Nobody knows, in fact, what death is, not whether to man it is not perchance the greatest of all blessings, yet people fear it as if they surely knew it to be the worst of all evils." Herein Socrates describes death as rather pleasant and not to be feared. This predated Christian thought that came to a similar conclusion several hundred years later.

We physicians who are constantly concerned with life and death have always known; it is life that is painful, death is easy and a great release.

It is, therefore, paradoxical that in our society of today there exists a law that requires the state to punish certain criminals by putting them to death. Is this then our approach, in a free and hopefully civilized society, to deter the most heinous of

crimes? We must admit there is little deterrent in our present method due to the lack of the prompt carrying-out of capital punishment and the unequal effect of its administration. What we have now is near random chance and anarchy in respect to the ability of an individual to predict the cost of his criminal behavior. For instance, in South Carolina, you will probably spend more time in jail for forgery than for voluntary manslaughter.

My thesis is that death, while the ultimate deprivation for an individual, is very little punishment. Further, that capital punishment is amoral in a civilized society. It is the worst of examples that a government can set for its citizens, that is, the killing of an individual in cold blood. What then can a free and civilized society do to deter the most heinous of crimes? There must be an alternative, something other than just being against the death penalty.

I would propose a new law. The person that would ordinarily be sentenced to death would instead be sentenced to what I like to call *lethe* (from Greek mythology meaning oblivion, or river of oblivion). That is, he would be placed in a cell alone with no chance of parole for the re-

mainder of his life; he would have no contact with anyone other than his jailers and he would never leave his cell. This would be real punishment and such a criminal may well yearn for the release of death. With such dire punishment, the prisoner should probably be offered a "cup of hemlock" on his tenth year of incarceration and annually thereafter; however, this latter would probably not be acceptable to a Christian society.

We physicians, who are in a constant battle with the grim-reaper, by our very nature should oppose the death penalty. An obvious civilized step forward was taken by the Council of the South Carolina Medical Association in 1982 when

a motion passed objecting to any physician taking part in carrying out capital punishment. If physicians should not take part in killing a prisoner, then should we be in favor of anyone doing so?

As physicians we could make a difference if we give our support and influence to the now emerging "South Carolina Coalition Against Capital Punishment." A better name for this organization might well be "The South Carolina Coalition for an Alternative to Capital Punishment."

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LETTERS TO THE EDITOR

To The Editor:

Re: "Think Yeast — the Expanding Spectrum of Candidiasis," September, 1984 issue of *The Journal of the South Carolina Medical Association*

While anecdotal observations may be of some value in medicine, the statements and conclusions made in the article, "Think Yeast," published in *The Journal of the South Carolina Medical Association*, September, 1984, are not supported by current research. Except for anecdotal observations, no well documented studies in the medical literature have shown that this type of therapeutic approach to allergic or emotional diseases would be of any benefit whatsoever.

Since the injudicious use of Nystatin and Ketoconazole might induce potential severe allergic reactions or initiate drug intolerance to these agents, it is essential that these drugs be used only in situations where they would reasonably be expected to be helpful. Certainly there is a well recognized condition of systemic candidiasis but this is not the disease described in this article.

The readership should be aware that in addition to allergic reactions and drug intolerances, there also exists the rare potentially serious hepatotoxic effect of Ketoconazole.

Unfortunately, we don't have the definitive therapy for many emotional and allergic diseases and it might be tempting to reach for certain anecdotal therapies with little proven scientific merit. Hopefully, continuous scientific efforts using the tools of objective research techniques

will give us the answers to these perplexing problems in the near future.

Yours very truly,

CHARLES H. BANOV, M.D.
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Charleston, S. C. 29403

The above letter was referred to the authors, whose response is as follows:

Dr. Banov refers to the article as anecdotal and that the statements and conclusions are not supported by current research.

In response, let me first comment on the term — anecdotal, a word that has recently crept into medical terminology. Webster defines anecdotal as a short entertaining account of some happening, usually personal or biographical.

The article "Think Yeast — The Expanding Spectrum of Candidiasis" is definitely not anecdotal. The paper was written to confirm the earlier reports of other physicians, and in particular, of Dr. C. Orian Truss, who began his studies in 1964. In addition, the Bibliography lists six references, including Dr. W. G. Crook's book, "The Yeast Connection," which itself contains fifty-five references.

Since publication of the paper, I am delighted to report Drs. Truss, Allan Levin, and Edward Winger, in independent studies have noted T-cell changes, lowering of the ratio of helper cells to

suppressor cells, and an elevation of the IgG and IgM in patients with chronic candidiasis. Dr. Kazue Iwata, of Tokyo, has spent a lifetime studying *Candida*, and has identified over fifty toxins produced by the yeast.

His observations were presented at the December 1983, Birmingham symposium "The Yeast-Human Interaction." He reported that toxins from several *Candida* strains:

1. Suppress T and B cells, both in number and function
2. Enhance vascular permeability
3. Promote the release of histamine
4. Induce anaphylactic reactions.

I agree with Dr. Banov that rare potentially serious hepatotoxic effects of Ketoconazole have been reported. I would expect any patient on

prolonged Ketoconazole to be monitored with liver function studies. To date, we have had no adverse effects from the use of Ketoconazole.

Nystatin, which has been around for over thirty years, is notably free of untoward reactions.

In summary, the purpose of the article was to confirm the results of the original reports, and to stimulate interest in the subject of chronic candidiasis. In view of the controversy generated, this article has definitely achieved its goal. I think my friend, Dr. Jim Willoughby says it best when he notes that if a physician isn't "up" on a subject, he tends to be "down" on it.

Sincerely yours,

MARTIN H. ZWERLING, M.D.
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LOCKING IN YIELDS: OPPORTUNITIES THAT RATE ATTENTION.

"A bird in the hand is worth two in the bush.".....Today's interest rates can bring to mind this old saying and add to its validity. Ever since fixed income investments were introduced, the question of whether to lock into today's rate or wait "until tomorrow" in hope of a better one has dogged even the most seasoned investors.....E.F. Hutton's outlook is for continued low inflation. And with rates apparently having peaked in June, the current economic environment translates into what could be a substantially profitable opportunity.

An Interesting Perspective: It's important to remember that the real rate of return - the spread between interest rates and the rate of inflation - reflects your actual spendable income from an investment. With the inflation rate currently hovering around 4% to 5% and interest rates approximately 7% to 8% higher, the current real rate of return is its highest in years.

Choosing the Right Key: There are literally dozens of ways to take advantage of the current favorable interest rate scenario in the taxable, tax-deferred and tax-exempt areas.....If you decide that tax-exempt investments are best-suited to your current needs, you can invest in:

Municipal bonds that offer income exempt not only from federal tax, but in many cases, state and local taxes as well. The bonds usually pay semi-annual interest and are available in a wide variety of terms and maturities, from several months to 30 years.

Zero Coupon municipal bonds that pay no semi-annual interest but allow you to earn up to 30 times your initial investment, since they are purchased at deep discounts from par and redeemed at par value at maturity.

Put bonds that lock in today's rates for a few years with an "escape clause" -- the option of selling bonds to their issuer after a specified period at par should current rates reverse themselves.

Tax exempt unit trusts - diversified, fixed portfolios of municipal bonds available for a minimum investment of \$1,000; and municipal bond funds, which are both diversified and professionally managed, with bonds traded regularly to maximize market opportunities. Both offer monthly tax-free distribution of income.

Your choice of taxable investments, whose yields are generally higher than tax-exempts, is equally extensive. These include corporate bonds and U.S. Treasury

bonds, bills and notes, which may have particularly attractive yields now. In addition, there are:

Certificates of deposit with maturities from three months to 10 years.

Corporate and government mutual bond funds.

Treasury Bond Receipts (TBRs) and Certificates of Accrual on Treasury Securities (CATS). Like zero coupon bonds, TBRs and CATS pay no current interest but offer investors a known return at a specific point in the future, with the added advantage of a U.S. government guarantee on the underlying government bond or note. Since investors are taxed yearly as if accrued interest were actually received, TBRs and CATS are excellent funding vehicles in tax-advantaged accounts such as IRAs or Keoghs.

COMPLETION PROGRAMS: OIL AND GAS OPPORTUNITY WITHOUT THE RISKS.

If you've always associated oil and gas investing with placing high stakes at high risk for potential high rewards, a completion program may disappoint you. That's because oil and gas completion programs combine relative safety and a potentially attractive rate of return with a participation price as low as \$5,000. So if you want to invest in oil and gas, but have steered clear in the past, consider a completion program.....A completion program is a limited partnership that enables you to share in the economic potential of oil and gas drilling without assuming traditional drilling risks. And, while some other programs -- such as oil and gas income limited partnerships -- offer attractive returns, they often don't give investors the tax advantages available in a completion program.

Last and Safest Phase: How does it work? Completion is the last and safest phase of oil and gas development. It involves installing the equipment needed to remove the oil and gas from the ground and bring it to market. It does not involve drilling Furthermore, the only wells included in completion programs are those that demonstrate the potential for successful production after they have been drilled to a total depth and tested for the presence of hydrocarbons.....The completion program finances a portion of these material costs. In return, program investors receive a share of production during the economic life of each well. If completion is unsuccessful and a well is plugged or abandoned, program investors may be provided with insurance to reimburse them for this loss.

Steady Income Stream: In short, the completion program can translate into a steady stream of income that could outpace the rate of inflation. This income stream may continue for approximately 15 years.....Tax benefits improve the economics even more. Investors are entitled to several deductions that shelter a significant portion of the income and, in addition, there is an attractive investment tax credit.....Industry reports indicate that the U.S. is currently experiencing its first real growth in oil consumption in the past five years, and might now offer better investment opportunities than have been available in recent years -- expecially in a low-risk program.

FURTHER INFORMATION

If you would like to receive further information on any of the topics covered in this newsletter, please write to Martin Lefkowitz, CFP, E.F. Hutton & Company, 2700 Middleburg Drive, Suite 200, Columbia, SC 29204; or Call (800) 922-1112.

* * * * *

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ON THE COVER: CHARLTON HENRY LELAND, M.D. 1829-1894

Charlton Henry Leland, M.D., presented his inaugural dissertation on *Cynanche Maligna* (L. Gangrenous Pharyngolaryngitis) to the Faculty of Medicine at the Medical College at Charleston, South Carolina in 1851. Dr. Leland described *C. Maligna* "as one of the most fatal diseases to which children are liable, often prevailing epidemically." He describes the symptoms as "languor, inability of motion, loss of appetite . . . great dejection often with nausea and vomiting." He noted that the "voice appeared also to have undergone a change, sometimes hoarse and in others unnaturally shrill" (no doubt due to the extension of diphtheritic membranes into the larynx).

Treatment at the time consisted of "the application of leeches to the angle of the jaw, and cups applied to the neck to reduce the swelling." "Purgatives and diaphoretics" seem to be used PRN. "Stimulating gargles of nitrite of soda, or alum, capsicum, vinegar and honey" were recommended. The French treatment was application "of a sponge, wet with hydrochloric acid to the membranes daily." To "excite the flagging circulation" he reported that "wine and even brandy were very serviceable."

Charlton Henry Leland (b. 1829, Charleston, South Carolina, d. 1894, McClellanville, South Carolina) was one of five accomplished sons of the distinguished theological Reverend Doctor Aaron W. Leland, who settled in Charleston after graduating from Williams College, Massachusetts, in 1808. The Reverend Doctor Leland held the pulpit of Charleston's First (Scots) Presbyterian Church when the present structure was constructed in 1816. Three of the Reverend Doctor Leland's sons became physicians, and two were scholars and professors. Briefly:

Charlton Henry Leland, M.D., received his Medical Degree in 1851 and practiced medicine in Darlington, South Carolina; Davidson, North Carolina; and Charleston, South Carolina. During

the Confederate War, he served as surgeon at Fort Johnson, Charleston, South Carolina.

Horace Wells Leland, M.D. (b. 1820, d. 1885) graduated from the Medical College of the State of South Carolina in 1843. His thesis was on "Derangements of the Catamenia." He died at the family's plantation, Walnut Grove, in Charleston County.

Samuel Wells Leland, M.D. (b. 1824, d. 1856) wrote his thesis on "Inflammation" and received his degree from the Charleston Medical College in 1849. He practiced general medicine in Mills Creek near Columbia, South Carolina.

John Adams Leland (b. 1817, d. 1892) was educated at Williams College, as had been his father. He held the chair of mathematics at Davidson College in 1854, but after five years "fearing that North Carolina would not secede with South Carolina and that he should be left in the Union," he moved to South Carolina. In 1861, he formed a company of men known as the Trenton Rifles which was composed primarily of his former students. This unit achieved many distinctions during its service in the war. After the war, Major Leland was called to the Presidency of Laurens Female College.

James Hibben Leland (b. 1810, d. 1897) took his education in mathematics and Latin at Amherst College in Massachusetts, and was called as Headmaster of the Mt. Pleasant Academy (near Charleston, South Carolina). Piously religious like his Puritan father, Professor James Hibben Leland was an "ardent advocate of state's rights and devoted son of South Carolina."

Many other descendents of the Reverend Doctor Aaron Whitney Leland have entered the professions of medicine and higher education; all have contributed to the "history of medicine in South Carolina."

— THOMAS M. LELAND, M.D., Ph.D.

INFORMATION FOR AUTHORS

We encourage original articles and letters to the editor of potential benefit and interest to the members of the South Carolina Medical Association.

CORRESPONDENCE: All manuscripts and correspondence should be addressed:

The Editor

JOURNAL OF THE SOUTH CAROLINA
MEDICAL ASSOCIATION

Post Office Box 11188

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The above takes into account *The Copyright Revision Act of 1976*, effective January 1, 1978. We request authors to advise the editor of any prior or anticipated duplication of their work in other publications. Submission of material as a "companion article" to material submitted elsewhere is discouraged.

PRIORITY FOR PUBLICATION: *The Journal* was founded in 1905 especially as a place for practicing physicians to publish their original observations. This purpose continues to receive priority. Growth of institutions, especially of medical school faculties, during this century may be, at least in part, responsible for a decreased tendency for practicing physicians to attempt scholarly work. Concerned about this trend, *The Journal* encourages practicing physicians to report original observations, including series of cases or individual case reports.

The Journal also welcomes timely review articles by institution-based physicians. However, it is the philosophy of the Editorial Board that state medical journals do not represent an appropriate forum for research findings of a specialized nature. Such findings, it is felt, belong in national or regional specialty or subspecialty journals. Articles by institution-based physicians should serve

the information needs of a general physician readership.

Articles dealing with social, economic, and ethical issues are strongly encouraged. Historical or philosophical essays are also welcomed, although these are given lower priority compared to the above categories.

TYPES OF ARTICLES ESPECIALLY WELCOMED FOR CONSIDERATION

1. Original scientific observations (*including* case reports) made by practicing physicians.
2. Concise, timely review articles (see "Priority for Publication").
3. Articles pertaining to current social, economic, and/or ethical issues affecting the practice of medicine.
4. Information uniquely pertinent to the health care of South Carolinians.

REVIEWING AND RESPONSIBILITY TO READERSHIP: We will make every effort to review manuscripts promptly. All manuscripts will be reviewed by our editorial office, and when indicated the opinions of outside consultants will be solicited.

We welcome criticisms of journal content by members of the South Carolina Medical Association.

REPRINTS: These will be made available by the publisher at established rates, at the time of mailing of galley proofs.

LENGTH OF ARTICLES: We prefer concise articles of approximately 2,500 words (approximately 8 typewritten pages, double-spaced), with no more than ten references.

We regret that space considerations limit our ability to publish longer articles, and request that authors adhere to the above guidelines. Similarly, tables and illustrations (see below), should be kept to a minimum, and be specific and pertinent.

Authors desiring to make additional data or additional references available to readers are encouraged to do so by adding footnotes to the effect that "additional references (or tables derived from this data base, etc.) are available from the author(s) upon request."

MANUSCRIPTS: These should be typewritten, double-spaced, and on one side of the paper. The original and one copy should be submitted. The title page should indicate the title, author(s), author's address, and academic appointments, if any. We request that the author's name not appear on subsequent pages, to permit "blind" review of the article, when desired. Authors should retain one copy for use in proofing. Written correspondence concerning proposed (potential) manuscripts is welcomed.

ILLUSTRATIONS: These should be submitted as glossy, black-and-white prints no larger than a standard page; smaller prints are desired. Ordinarily, publication of 4 small illustrations or tables, or the equivalent, will be paid for by *The Journal*. Any number beyond this must be paid for by the author except under unusual conditions. Illustrations should not be mounted, stapled, or clipped. On the back side of each illustration, the article title, figure number, and top of figure (but not the author) should be noted lightly in pencil. Legends for illustrations should be typed on a separate sheet of paper.

REFERENCES: These should be cited consecutively in the text, in superscript, e.g., "Bottsford, *et al.*³ . . ." We recommend no more than ten references, selected from more recent publications in accessible journals in most instances. Standard journal abbreviations should be used, with the style for journal articles being as follows:

³ Bottsford JE, Bearden RC, Bottsford JG: A ten year community hospital experience with abdominal aorta aneurysms. *J S C Med Assoc* 79: 57-62, 1983.

MATERIAL FOR COVER: The illustrations for the cover of *The Journal* are selected by a member of the Editorial Board, Thomas M. Leland, M.D., 2741 Speissegger Drive, Charleston, SC 29405. Dr. Leland welcomes illustrations and suggestions for the cover, including appropriate commentary. Such suggestions should be sent to him in writing at the above address.

ROE FOUNDATION AWARDS

Through a gift by the Roe Foundation, a Thomas A. Roe and Shirley W. Roe award of \$3,000 will be given each year at the annual meeting beginning in 1985. All manuscripts submitted by South Carolina physicians will be considered for the award. The award will be made, on alternate years, to a practicing physician or to an institution-based physician, and will be based on articles published in *The Journal* during the two previous years.

Articles written by practicing physicians will be judged by members of the Editorial Board of *The Journal* on the basis of original scientific content and clarity of presentation. Practicing physicians are encouraged to report observations in *The Journal*, which was originally established for this purpose.

Articles written by institution-based physicians will be judged by outside referees, to be selected by the Editorial Board. The current editorial policy of *The Journal* is that original scientific observations made by physicians such as medical school faculty members should, ordinarily, be submitted to peer-reviewed specialty journals rather than to the state medical journal. Therefore, the Thomas A. Roe and Shirley W. Roe award will be based on *review articles* by institution-based physicians. Referees will be instructed to base their selection on (1) the quality of the review article, and specifically its instructional value for a general physician readership, and (2) the significance of the author's contributions to his or her field. Institution-based physicians should submit a current curriculum vitae and reprints of articles representative of their work, as published in specialty publications.

SOUTH CAROLINA MEDICAL ASSOCIATION AUXILIARY



MALPRACTICE IS A FAMILY AFFAIR

Every South Carolina medical family deserves to have the advantage of an organized Malpractice Litigation Support Group. Local societies and auxiliaries must work together to help each other find a better way to face the enormous amount of stress in everyday living brought on by malpractice litigation. Because the entire family is involved, husbands and wives need to meet together to explore the problems, improvements and goals of our medical communities in addressing the malpractice situation. Education is the key factor in strengthening our defenses to combat STRESS.

In Greenville there have been four malpractice meetings since the support group was organized in November, 1983. Subjects have included: Stress In Relation to Medical Malpractice; Malpractice: The Effect of the Media; The Effect of the Physician's Public Image; A Malpractice Case from Beginning to End; Resources in the Battle Against Malpractice Litigation. These meetings were attended by physicians and wives who have already undergone litigation, those who have a case pending and those who have never felt the sting of a lawsuit. Open discussion always follows the program and an atmosphere of emotional support prevails.

A steering committee meets after each general meeting for review, evaluation and planning. This committee is served by the President of the auxiliary, the President of the medical society plus five appointed members from each organization. The purpose of the committee is "to serve and to collect information." This is being accomplished through offering informed speakers, through personal contact with anyone seeking support before or during a trial and through exchanges of printed information. Members have written letters and articles, have talked with newspaper representatives and hospital personnel and have been kept informed about risk management progress on the state level.

Every medical community is encouraged to organize a support group. It does not take a lot of time for we have learned that every aspect of malpractice is slow. Litigation can go on for years. This is one reason the family feels so much pressure. Litigation does not stop to observe events such as Christmas, a birthday, a daughter's wedding, a baby's arrival, the death of a parent.

A statewide office has been established for an exchange of information for support groups. A file has been set up under the direction of Mrs. Joy Drennen, Editor of the "Risk Management Bulletin" and Manager of Information Services. Included in the material you may order: an article about stress by Sara C. Charles, M.D., titled "Malpractice: A Different View" (March 1984); a presentation by Salvatore A. Rini, M.D., titled "An Update of the Professional Liability Crisis" (Nov. 1983); detailed reports of the general meetings in Greenville; and copies of the booklet, "Understanding Malpractice Claims." Do you have an article or report to share? Send it to Joy. She may be contacted at SCMA, P. O. Box 11188, Columbia, SC 29211 (telephone 798-6207). We need your contributions to make the exchange effective.

SCMA members are hard at work to develop the Risk Management Program. The "Medical Malpractice Bulletin," published quarterly, is mailed to all state physicians. It is meant to be shared with the spouse for she, also, needs to read this life-line publication. Our doctors are being abused and we want to help.

There is no place for apathy here. It was Will Rogers who said, "Even if you're on the right track, you'll get run over if you just sit there."

MARGARET B. ASHMORE, *Chairman*
Greenville Malpractice Support Group

DO YOU KNOW A DISABLED PHYSICIAN?

SCMA CAN HELP

TURN PAGE TO LEARN HOW

DO YOU KNOW A DISABLED PHYSICIAN?

THE SOUTH CAROLINA MEDICAL ASSOCIATION CAN HELP

The SCMA's Committee on Alcohol, Drug Abuse and Impaired Physicians is the disabled doctor's advocate. The Committee views abuse and addiction to alcohol and other drugs as an illness and deals with it non-judgementally, non-punitively and therapeutically.

The program functions as a peer to peer activity, whereby an impaired physician will undergo evaluation and receive a treatment program tailored to his or her specific needs in work, family, finances and community. Voluntary participation results in committee advocacy and a protective role with the local hospital, medical society, State Board of Medical Examiners and Drug Enforcement Agency. Voluntary participants following through with treatment are not reported to either the State Board or any other group or agency.

WHAT IS AN IMPAIRMENT?

The impaired physician has been defined as one who for any reason is unable to perform professionally at an optimal capacity. That is to say any disability (impairment) that causes a physician to be unable to do anything other than his very best. It is felt by this committee that this definition covers everything from Alzheimer's disease to Alcoholism. This committee has been asked by the State Medical Association to address all forms of impairment or disability in regards to the physicians in the State.

WHAT CAN YOU DO?

Disabled doctors are usually unable to ask for aid themselves. You can help them by:

Writing: George M. Grimball, M.D., Chairman
Committee on Alcohol, Drug Abuse and Impaired Physicians
South Carolina Medical Association
P. O. Box 11188
Columbia, SC 29211
(803) 271-9145

Calling: SCMA Headquarters, (803) 252-6311 or after hours
leave your message at (803) 765-9347

WHAT THE COMMITTEE WILL DO

Your report will be investigated by a committee member and if verified, a pair of committee members will contact the impaired physician. Should they fail to recruit the physician, a second and third team will follow. The physician signs a contract with SCMA limiting, as mutually agreeable, his or her practice and enters treatment. A second contract is executed following treatment for follow-up and assistance in maintaining recovery. At this time a colleague is also appointed to work with the impaired physician for a period of up to two years.

CARING AND ANONYMITY ARE KEYS TO THE SUCCESS OF THIS PROGRAM

President's Page



WHY SHOULD WE SUPPORT OUR SPORTS MEDICINE COMMITTEE?

Three years ago, the Medical Aspects of Sports Committee requested and was granted a three-hour segment of the clinical aspect of our Annual Meeting. The program presented was outstanding and no one, least of all the committee members, anticipated that participation by our membership would be so significant as to overflow the accommodations provided for the program.

All aspects of the programs presented at the Annual Meeting have now been increased and solidified, and the Sports Medicine program is a permanent portion of the clinical program.

In addition, the committee has offered sports mini-clinics in any county so requesting the program in an effort to educate coaches, trainers and other groups sponsoring sports programs concerning the treatment and prevention of sports injuries.

I want to urge every county medical society which has not availed itself of the opportunity to participate in such a program to begin the necessary preparations for such a clinic during the summer of 1985. The effect of these programs not only will benefit all those who are responsible for the athletic activities in their schools, but the more significant effect is directed to the athletes. Our benefit is professional and aesthetic — there is no better opportunity for each county society to obtain complete coverage by notifying the news media of these clinics (TV, radio, newspapers).

The members of the committee are available to assist in planning and conducting the clinic. The Association will provide whatever administrative assistance is needed.

On behalf of the South Carolina Medical Association, I would like to thank the members of the Medical Aspects of Sports Committee for their dedication to the profession and to the improvement in the way in which young athletes are handled to allow them to reach their most productive potential. I would especially like to thank Dr. Roland Knight for his continued service to this Association as the Chairman of this committee. He has not requested any change and persists in offering more to the profession than anyone serving in such a position.

Until next month,

A handwritten signature in dark ink, appearing to read 'Ken', with a long, sweeping horizontal line extending to the right.

KENNETH N. OWENS, M.D.
President



THE JOURNAL

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All manuscripts should be accompanied by a transmittal letter with the following paragraph: "This original work has not been submitted or published elsewhere, in entirety or in part. I (we) hereby transfer, assign, or otherwise convey all copyright ownership to the South Carolina Medical Association in the event that this work is published by the SCMA."

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From the State House: LEGISLATIVE UPDATE



February 1985

The South Carolina General Assembly is now well into the '85-86 session and just now beginning to pick up steam. Many actions have been coming about slowly--probably because of great leadership changes in the Senate which have had reverberations in the House of Representatives. Nuclear waste has become a big issue along with seat belt legislation and blue laws reform.

In the medical realm, things started with a bang and haven't let up. One major hearing has been held on the subject of indigent care (see discussion below) and also on three other medically important topics. Numerous other issues are demanding our attention in what seems to be thus far the most active year ever for SCMA.

"INSURANCE EQUALITY" BILLS GAIN SPOTLIGHT

In January, four bills were introduced to mandate that when physicians are reimbursed under health insurance policies for certain procedures that other non-MD professionals who perform similar procedures must also be reimbursed by private insurance companies to the same extent. SCMA has historically opposed laws mandating benefits in health policies.

The bills introduced pertain to Psychologists (S-11, introduced in the Senate and H-2055, introduced in the House) and Chiropractors (see S-53, introduced in the State Senate, and H-2319, introduced in the House) and the benefits under the legislative directives would have to be focused toward them. On January 31, H-2055 (mandating coverage for Psychologists) was the subject of a hearing before a House Medical Affairs Subcommittee.

Hospitals, physicians (SCMA), the insurance industry, and representatives from business and industry testified in opposition. They cited (1) the lack of demand from the public for inclusion of such coverages, (2) the fact that such coverage is available now as options in most policies, (3) the cost to non-users goes up when you mandate coverages to industry, consumers, etc., (large business concerns, of course, pay for the coverage for their employees), (4) the high probable financial impact on health care costs in general due to higher utilization by these particular professions, and (5) the sentiment that the government should not be telling private insurance companies what they should cover in health care policies. These were just some of the arguments against this measure.

Only Psychologists (and other professionals such as Chiropractors, Optometrists, etc.,—who hope to pass legislation for their own bailiwick in the near future) supported the concept. They argued that they are being "unfairly kept out of the lucrative insurance market" via a discriminatory conspiracy by doctors, hospitals, and insurance companies.

FRANK ROGERS ACCEPTS NEW POSITION

Frank Rogers, who has served as SCMA's attorney and state government representative for almost seven years, is leaving March 1 to assume a similar position in North Carolina. He has been appointed Manager of Governmental Affairs for Glaxo, Inc., a national pharmaceuticals concern with corporate headquarters at Research Triangle Park, N.C.

Rogers will supervise Glaxo's legislative liaison program in all 50 states in addition to overseeing its congressional efforts in Washington, D.C.

SCMA's legislative program is continuing a revamping and upgrading that began to take shape last year. Bill Mahon, the organization's Executive Vice President, is becoming a familiar face at the Legislature where he is functioning as a full-time lobbyist. Additionally, Ron Scott, a prominent Columbia attorney and former aide to several Senate Committees, is serving as an advisor and legislative liaison for SCMA. Another full-time governmental affairs person is expected to be added to staff as a replacement for Frank late this month.

The clerical administrative staff has also been reorganized to provide greater assistance to the legislative program. Along with the extra staff are the new word processors to get letters out quickly to the SCMA SCAPELL (South Carolina Auxiliary-Physician Educational Legislative Liaison) program.

Rogers, in commenting on his leaving, noted: "When I came on board in 1978, I could easily do both the legislative and legal work that needed to be done; not so anymore. Since that time, the focus on legislation has shifted from Washington to the States, and paramedical groups are more prone to attacking the high standards set by medicine. The Association is wise in strengthening the legislative program."

INDIGENT CARE PACKAGE GETS HEARING

The medically indigent assistance bill in the form of H-2118 (there is also a senate version, S-112 which is in the Senate Medical Affairs Committee) was the subject of a hearing on January 30 before the House Medical Affairs Committee. SCMA testified in support of the concept and cited its many projects as evidence of our efforts to provide for the indigent in South Carolina. Quite a number of other prominent entities including the Governor's office, the State Hospital Association, and representatives of the Health Care Planning and Oversight Committee testified in support. The measure now has snowballed and appears headed for relatively easy passage into law.

The bill as drafted would call for the appropriation of \$15 million in state funds, an assessment on counties of \$7.5 million and a tax on participating hospitals of \$7.5 million. This would be paired up with an attractive matching program of the Federal Government—making a grand total of some \$90 million. A large amount of this would pay for indigent care costs in hospitals across the state. The legislation would also increase the AFDC Standard of Need thereby increasing the eligible Medicaid population by 42,600.

"LIVING WILL" LEGISLATION PASSES HOUSE OF REPRESENTATIVES

SCMA has long supported a bill to provide for a "Living Will" type document which would allow a terminally ill patient to instruct a doctor not to utilize life sustaining equipment or procedures in certain undisputable cases.

The Living Will legislation, in the form of House bill H-2041, stipulates that the document utilized for this purpose must take on many aspects similar to an actual Will left by a deceased person. There are also a number of safeguards to prevent against possible abuse or manipulation of a terminally ill patient. Additionally, the document allows for easy (even verbal) revocation by the patient himself.

Our association is in support of this measure due to the fact that there is oftentimes much confusion as to what should be done in cases where patients are terminally ill. Physicians and other health support personnel are not always sure of the legal, social, and ethical ramifications of their decisions. This proposed law will help in that regard.



CARDIOVASCULAR DISEASE AND COST — AN INTRODUCTION

E. CONYERS O'BRYAN, M.D.*

At the completion of a lecture on the treatment of refractory congestive heart failure, a seasoned family practitioner remarked that he had taken careful notes and felt comfortable in a plan to handle patients with this clinical entity but also estimated that over fifty percent of his patients would be unable to afford the medications on a daily basis.

As referral physicians we often fall into the trap of outlining academic plans which fail in the "real world" of patient compliance. It is hoped that this special issue of *The Journal* will offer some practical hints on managing the foremost common problems in cardiovascular disease often requiring multiple medications — seldom at low costs.

An unfortunate truism in clinical medicine is that the most ill patients characteristically require the most costly therapy while earning the lowest incomes.

It is beyond the scope of this special issue to debate the therapeutic efficacy and possible cost-containment of invasive treatments such as aortocoronary bypass, intracoronary Streptokinase, and angioplasty which may later reduce the number of medications required over a prolonged period of time and promote earlier return to work.

Another knotty clinical problem is deciding when to reduce multiple drug therapy when patients stabilize or improve objectively, subjectively, or both. We know from experience that a significant number of patients with cardiovascular disease, and particularly those with arterio-

sclerotic heart disease, will improve with time and may safely have a reduction or even discontinuing most of their medications.

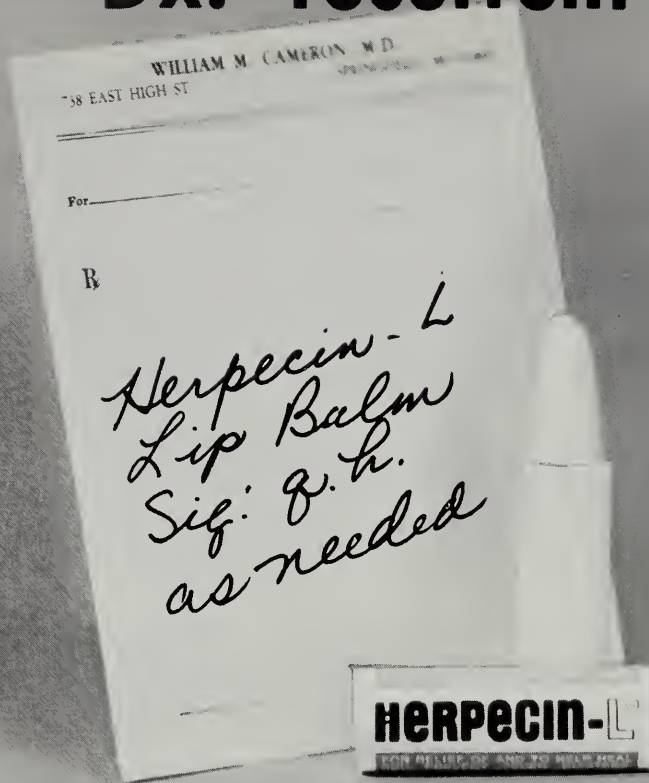
Every physician involuntarily groans when confronted with a patient who has multiple diseases accompanied by two family members required to carry the sacks of medicines. This issue highlights means of optimally treating with less medications and achieving the same or improved clinical goals. For instance, a beta blocker may be used to treat the angina patient with ventricular ectopy who is also hypertensive and even may have migraine headaches. The calcium channel blocker agent, Nifedipine, may be used for treatment for obstructive and spasm angina, hypertensive vascular disease and peripheral vascular arterial insufficiency (including Raynaud's).

Another calcium blocking agent, Verapamil, may be used to treat angina and re-entrant supraventricular tachycardias as well as hypertension.

The applauded significant decline in cardiovascular disease and mortality over the past two decades has been accompanied by technological and pharmacologic advances of explosive proportions and it is certainly not the intent of this special issue of *The Journal* to suggest at anytime that quality patient care be compromised because of cost. The contributing authors to this special issue of *The Journal* have all had excellent academic and practical treatment backgrounds and we are indeed fortunate for the opportunity to share their expertise. □

* 501 S. Coit Street, Florence, S. C. 29501.

Dx: recurrent herpes labialis



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COST CONTAINMENT AND THE TREATMENT OF HYPERTENSION

SHAWN A. CHILLAG, M.D.*

Cost containment in medicine refers to limiting the expense of evaluation and therapy. Cost containment is different from cost effectiveness which attempts to determine if the costs of the medical endeavor are justified given the anticipated benefits. Clearly, cost containment cannot be totally separated from cost effectiveness, but much of the arbitrary monetary value placed on an outcome is avoided. Cost effectiveness decisions determine whether to treat; cost containment strategies attempt to provide this treatment as inexpensively as is prudent. Sixty million adults in the United States have hypertension.¹ The average internist, family practitioner, or general practitioner sees 20 to 40 patients with hypertension per week. Accurate diagnosis, appropriate evaluation and timely reasoned therapy are the keystones of effective management of hypertensive patients.

The diagnosis of hypertension carries with it profound implications for the individual. Even when mild hypertension is present the treatment can be worse than the disease. Proper consideration should be taken before a label is applied and life insurance premiums elevate or coverage is jeopardized. Ambulatory and home blood pressures are lower than those taken in the office.² However, blood pressures taken in a medical setting are usually the basis for the risk profiles for hypertension or for judging the effectiveness of treatment. Home blood pressure monitoring is a rational basis for initiating and adjusting therapy after a "casual" high reading has been found. It is somewhat frightening that a measurement that is so important is undertaken in such a casual fashion. A discussion of the accurate measurement of blood pressure is beyond the scope of this paper, but there is an excellent recent review that demonstrates many potential pitfalls in the measurement of blood pressure.³ The Joint National

Committee (JNC) recommendations for classification of blood pressure are reasonable for the most part (Table I).⁴ The higher the blood pressure is, the greater the mortality. This is true even at "normal" levels, but the benefits of therapy are miniscule. The alphabet soup of clinical trials (HDFP, VA, MRFIT) have failed to convincingly prove that the treatment of mild diastolic hypertension (90-100 mm Hg) is beneficial.⁵⁻⁸ In the *absence* of other significant cardiovascular risk factors, my inclination is to delay pharmacologic treatment of diastolic hypertension in the 90 to 94 mm Hg range for up to one year. Non-pharmacologic therapy (weight control, cessation of tobacco use, a decreased salt diet and even relaxation methods) should be especially strongly pursued in this borderline group. If everyone with hypertension of 160/95 mm Hg or greater were treated with medicines, the annual expenditure would more than double from \$2.0 billion to \$4.3 billion.⁹ This excludes detection, verification and initial diagnostic evaluation. The cost for preventing a single coronary event (based on Framingham data) in a 55-year-old hypertensive male is \$11,000 and for a female, \$21,000.¹⁰ In a 40-year-old woman, treatment of a diastolic of 100 mm Hg costs \$10,000 for each year of quality-adjusted life expectancy saved.⁹ It is \$6,000 if the diastolic is 110 mm Hg.

Table I
CLASSIFICATION OF BLOOD PRESSURE*

Diastolic — mm Hg	
less than 85	— normal
85 — 89	— high normal
90 — 104	— mild hypertension
105 — 114	— moderate
greater than 115	— severe
Systolic, when diastolic less than 90	
less than 140	— normal
140 — 159	— borderline isolated systolic hypertension
greater than 160	— isolated systolic

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* JNC Report⁴

TREATMENT OF HYPERTENSION

Whom to evaluate with laboratory testing and the nature of the testing are important in cost containment. The history and physical examination will direct the laboratory evaluation. The JNC report gives very useful guidelines for a disease specific intake evaluation. The initial tests recommended by the JNC (Table II) are reasonable. Other testing for secondary hypertension should be directed by the above data. Those hypertensive patients with family history of thyroid or adrenal tumors, with onset before age 30 or past age 55, with unusual signs or symptoms (weight loss, heart palpitations, hematuria, hypokalemia, hypercalcemia or renal failure), with uncontrollable hypertension or with rapidly rising levels of blood pressure and rapid blood vessel damage despite therapy should be considered for rapid sequence intravenous pyelogram, renin profiling, digital subtraction angiography, urine electrolytes, etc.¹¹

After the diagnosis has been established, the decision to treat should be made in concert with the patient. The patient should have a reasonable understanding of the problem and realize that long term follow-up and perhaps therapy will be required. Education about the problems and sequelae of hypertension makes for an informed and understanding patient, but is unlikely to help with compliance with the therapeutic regimen. The extensive review by Sackett and Haynes did not support that education of the patient about the disease process effectively improves compliance.¹² Non-pharmacologic measures should be recommended prior to pharmacologic management in the mild hypertensive, and these measures should continue to be supported by the physician after medications are needed. However, compliance is very poor with diet, smoking and exercise prescriptions. Compliance with pharmacologic regimens is hardly more than fifty percent. Incomplete adherence dramatically escalates the costs of the benefits. The therapeutic regimen must be designed for effectiveness, but if it is not taken all is lost. Of the fantastic number of variables reviewed that could affect compliance, only a few are under the control of the physician. When more than two medications are prescribed, when more than twice a day dosing is required, when the duration of therapy is greater than five days, and when in the older patient costs are high, compliance rapidly falls away.¹³ Of these factors, only duration of therapy cannot benefit from

Table II
LABORATORY TESTING IN HYPERTENSION*

hemoglobin	ECG
hematocrit	total cholesterol
urinalysis	High Density Lipoprotein cholesterol
potassium	fasting glucose
creatinine	uric acid

* JNC Report⁴

appropriate manipulation in the hypertensive patient. It must be remembered that the bottom-line is control of blood pressure, whether control be by the newest medication with numerous theoretical advantages, by moss placed in the shoe as by a recent patient or by root medicine. Whatever intervention controls the blood pressure with minimal interference in the patient's life is the best medicine. The characteristics of such an ideal medication regimen are relief of increased peripheral vascular resistance; inexpensive, twice or less daily dosing; two or fewer medications; few side effects and little follow-up laboratory testing required.

The stepped-care approach to antihypertensive therapy is very useful as outlined in the JNC, but there are several other maneuvers to be tried that may improve this approach. To Step 1 drugs, prazosin should be added as an effective agent with few side effects. It attacks the etiology of most hypertension, increased peripheral vascular resistance, unlike B-blockers and diuretics. Prazosin does not have the deleterious effects on potassium, glucose, cholesterol, uric acid, bronchial smooth muscle, heart rate or myocardial contractility.^{14, 15} Unfortunately, it is more expensive than diuretics and usually requires at least twice a day dosing. There is strong feeling that rather than pushing a Step 1 drug to maximally recommended or tolerable levels and then adding a Step 2 drug, that modest dosages should be used.¹ The additional patients controlled by going from 50 mg of hydrochlorothiazide (HCTZ) to 100 mg are few, but the side effects are multiplied. Now would be the time for "substitution therapy." Many patients may be controlled on one first line drug when they have failed on another class of drug.¹⁶ Because there is no great urgency in mild hypertension, the switch between diuretic, B-blocker and other adrenergic inhibiting agents (reserpine, clonidine, methyldopa, pra-

zosin) may be made. Blacks may respond better to thiazide diuretics, and whites may respond better to B-blockers.^{17, 18} If blood pressure is well-controlled on a low or modest dose of a Step 1 drug, consideration should be given to reducing and/or discontinuing therapy and observing. Studies have shown this to be an effective maneuver in ten to 20 percent of mild hypertensives.^{19, 20} This may be particularly advantageous if you did not initiate therapy, question the therapy or do not feel non-pharmacologic therapy was given an adequate trial. The non-diuretic medications may cause sodium retention so that dietary sodium restriction should be emphasized. Of course, if sodium retention took months to develop, there is no reason that short course or intermittent diuretics cannot be tried. Dosages and medications should not be changed too frequently (3-4 weeks) because it takes a while to reach a steady state.

There are several simple prescribing maneuvers that may lessen cost and reduce the number of medications and pills. Combination medications are often regaled against because there is little flexibility in dosing. So what? It may save money, although usually not much because the combined drug usually includes a cheap thiazide. More importantly it reduces the numbers of pills — one of the few proven methods of improving compliance. As the naval couplet says,

“Of what avail the loaded gun, torpedo, or
the shell

if signals fail, the fleet will go to hell.”²¹

One hundred pills or multiples thereof are often much less costly than an exact month's supply. This is especially true for inexpensive drugs. Thirty of the 50 mg hydrochlorothiazide tablets are \$2.65; 100 are \$3.35. Medicaid regulations do not allow this type of prescribing. When the dosage range is wide, often multiple size scored tablets are available. When financial considerations are paramount, ½ tablets of a larger sized tablet may be less expensive than the equivalent smaller sized whole tablet. Thirty of the 20 mg furosemide tablets cost \$2.85, thirty of the 40 mg tablets are \$3.00. With a few exceptions, generic substitutions have therapeutic equivalency. When a drug that has had a strong hype previously and is no longer advertised or detailed, it has usually gone off patent.

Diuretics are and should be frequently used as Step 1 therapy, especially in blacks, as mentioned earlier, and in the elderly. The elderly hyperten-

sive often responds well to low doses of diuretics.²² Beta-blocking agents are more likely to cause problems in the older patient. There will be fewer problems with hypokalemia when a maximum dose comparable to 50 mg of hydrochlorothiazide (HCTZ) is used. Twenty-five or 12.5 mg should be the starting dose. Nonetheless, hypokalemia may be a problem, especially in the patient with cardiac disease or when digitalis is also prescribed. Furosemide is probably as effective as HCTZ in hypertension and causes less hypokalemia than HCTZ alone or even when HCTZ is used in combination with a potassium sparing diuretic.²³ When potassium supplements are required, high potassium foods are probably the most expensive way to supplement potassium. The least expensive potassium supplement is a salt substitute. For example, 5 gm of Morton's Salt substitute (1 level teaspoon) supplies 60 meq of KCL for about one tenth of the cost of the least expensive prescription potassium supplement.²⁴ One-half teaspoon could be used twice daily at meal time.

When another problem requiring pharmacologic management is present along with hypertension, a change to a medication that effectively treats both problems may reduce costs and improve compliance. The hypertensive patient who develops angina might have both problems wholly or partly treated with a calcium channel blocker. Beta blockers are very useful in migraine sufferers, so that if hypertension is present, this group is a likely first choice in therapy. Other combination uses for B-blockers in hypertension include mitral valve prolapse, arrhythmias, hypertrophic cardiomyopathy and post-myocardial infarction. An arterial and venous dilator such as prazosin or an arterial dilator such as hydralazine can treat hypertension and congestive heart failure. Hypercalciuria calcium stone formers with hypertension could have thiazides included in their regimen. The hypertensive insomniac might benefit from the nocturnal use of reserpine, clonidine or methyldopa. As the number of agents increase that attack the treatment of various parts of the schema of hypertension, multiple uses for medications will grow.

The costs of evaluating and treating hypertension are usually not significant barriers to the success of therapy. It is a relatively inexpensive disease directly, but there are so many millions who may develop expensive renal, cardiac or cerebrovascular disease that therapeutic regimens

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for containing cost and improving compliance are of vast importance. Cost and compliance are inseparable. These treatment suggestions reflect this opinion:

1. Observe mild hypertension for months prior to making a diagnosis.
2. Consider longer observation when the diastolic pressure is 90-94 mm Hg when other cardiovascular risk factors are absent.
3. Try non-pharmacologic therapy first and continue to stress such therapy if medications are needed.
4. The stepped care approach should continue to be used with some modification.
5. Substitute Step 1 drugs for one another if therapy is ineffective prior to Step 2.
6. Do not push to maximal dosages unless well tolerated.
7. Allow dosage and medication adjustments time to succeed (three to four weeks).
8. Attempt single daily dosing; bid dosing may work even when tid and qid are recommended.
9. Step down or discontinue therapy after good control has been easily obtained.
10. Home blood pressure monitoring has much to recommend it.
11. Try to use no more than two medications; use combination drugs when feasible.
12. Generics are generally safe and less expensive.
13. One hundred pills or multiples thereof are less costly than odd lot monthly supplies.
14. Larger size pills are cheaper on a per milligram basis.
15. Salt substitutes are the least expensive way to supplement potassium.
16. Use one drug for more than one disease when possible. □

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A CASE OF CONGESTIVE HEART FAILURE

PETER C. GAZES, M.D.*

A. This case began 22 years ago when Mr. Albert, an active lawyer, was 56 years old. At that time, he had an initial episode of substernal pain. Five years later, at age 61, he developed atrial flutter which responded to cardioversion. His physician prescribed quinidine 300 mg, tid to maintain sinus rhythm. For the next 14 years on this regimen, Mr. Albert had very infrequent angina, until 1981 when, after a prolonged attack of angina, he developed dyspnea. At this time, he was referred to us.

At examination, Mr. Albert appeared very ill. He had neck vein distention at 45 degrees from the horizontal, hepatomegaly, cardiomegaly, at S₃ gallop, bibasilar rales, and peripheral edema. Non-specific ST-T changes were noted on his electrocardiogram, although no significant cardiac enzyme changes occurred. Chest x-ray revealed pulmonary congestion, pleural effusion and cardiomegaly.

- B. Our treatment choice was to give Mr. Albert a combination of digitalis and furosemide. Within one week, he lost 30 pounds and became compensated from a cardiac standpoint. Two weeks later, he was discharged on digoxin, oral nitrates, nitroglycerin ointment, and furosemide. Mr. Albert responded well to this regimen and remained compensated after two months. However, he complained that the frequent periods of diuresis were disturbing his social life. Our decision was to discontinue C. his furosemide and start him on bumetanide 1 mg/day. On this regimen, Mr. Albert did well for over a year. However, 14 months after his hospitalization, he once again developed symptoms and physical findings of congestive heart failure. Our choice was to increase Mr. Albert's bumetanide to 3 mg/day and to add D. metolazone 5 mg a day and continue potassium supplements. He improved but his BUN went to 55, his creatinine to 1.8 and his

potassium to 3.1. We concluded that he developed prerenal azotemia. Our response was to discontinue Mr. Albert's dose of metolazone. Within a few days, his BUN and creatinine concentrations returned to normal values. On this regimen, Mr. Albert initially did well. However, two months later, he had to be readmitted to the hospital because of increasing dyspnea and peripheral edema. Again, he was found to have a neck vein distention, cardiomegaly, S₃ gallop, hepatomegaly and peripheral edema. Chest x-ray showed less pleural effusion and cardiomegaly. He was started on a combination of bumetanide 4 mg/day, spironolactone 100 mg bid and his dose of nitrol ointment was increased to two inches on the chest tid. His oral nitrates were continued.

Mr. Albert improved. The only remaining problem to solve was occasional nocturnal dyspnea and excessive fatigue. Mr. Albert was F. begun on hydralazine, 50 mg tid, as an after-load reducing agent. Once again, he improved. Radionuclide angiography revealed an ejection fraction of 21 percent. When last seen, Mr. Albert was still compensated but still suffered from some exertional dyspnea.

- A. Atrial flutter is very sensitive to DC shock. Quinidine is still one of our best agents to prevent further attack. In view of its half-life of six to eight hours, it will take at least 40 hours to reach a steady stable blood level. Therefore, the dosage should be adjusted at two-day intervals.
- B. Digitalis and a diuretic are indicated in this setting. Only patients with mild congestive heart failure should be treated with diuretics alone. Digitalis is usually effective for supraventricular arrhythmias. However, it should be given even in the presence of regular sinus rhythm, if one has cardiomegaly and an S₃ gallop. Furosemide (Lasix) is a loop diuretic and is effective even if there is renal damage. Hydrochlorothiazide is less expensive, less potent and does not work well if renal insufficiency is present.

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CONGESTIVE HEART FAILURE

- C. Bumetamide has a quicker onset of action and a shorter duration of action compared to other diuretics.
- D. Metolazone (Zaroxolyn, Diulo) is a very potent diuretic and is a sulfonamide similar to the thiazides and acts at the early distal tubule. Its action can persist for 24 hours. It is effective in the presence of renal disease, but can cause potassium loss and hypochloremia with resulting hypokalemic metabolic alkalosis.
- E. Potassium-sparing agents such as spironolactone (Aldactone), triamterene (Dyrenium) and amiloride (Midamor) work at distal sites as well as in the collecting duct. These are considered as the least potent diuretics and are given primarily to reduce the likelihood that hypokalemia will develop. They also can augment the diuresis induced by other diuretics. The potassium-sparing agents have a slow onset of action, usually eight to 24 hours and must be continued for several days to achieve maximal effect. Nitrates, in addition to their action of dilating the coronaries and collaterals also reduce the preload (venodilator) which will drop the left ventricular end diastolic pressure and lessen dyspnea. It can be

administered sublingually, transdermally, or orally. The oral dosage will be up to 40 mg q.i.d. since the liver has to be saturated before a systemic response occurs.

- F. Hydralazine is an arteriole dilator that reduces peripheral vascular resistance and the after-load. □

Table I
MEDICATION COST

Name of Drug		Cost per Tablet (Based on quantities of 100)
Quinidine Sulfate	300 mg.	13¢
Digoxin	.25 mg.	3.5¢
Furosemide (Lasix)	40 mg.	13.5¢
Bumetanide (Bumex)	1 mg.	13¢
Metolazone (Diulo or Zaroxolyn)	5 mg.	18¢
Spironolactone (Aldactone)	50 mg.	42¢
Triameterene (Dyrenium)	100 mg.	20¢
Amiloride	5 mg.	23¢
Hydrochlorothiazide	50 mg.	4.5¢
Hydralazine (Apresoline)	50 mg.	18¢
Captopril	25 mg.	26¢
Sublingual Nitro	1/150	4¢
Oral Isorbide Dinitrate	10 mg.	11¢
Nitro Disc Patch	10 mg.	1.00
Nitro Dur Patch	5 mg.	96¢
Transderm Nitro	5 mg.	1.00
Nitrol Oint.	1 tube	3.00

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SCMA

NEWSLETTER

February, 1985

BLUES CREATE CONFUSION AMONG MIT MEMBERS

Recently, the SCMA Members' Insurance Trust elected to change from Blue Cross and Blue Shield to *Provident Life and Accident Company* for the claims administration of the SCMA MIT self-insured program.

As a result, Blue Cross and Blue Shield has been using the MIT subscriber list in marketing the Blue Cross and Blue Shield "Dimension" program. In their "marketing" efforts, they have been giving the erroneous impression that MIT members will no longer have health insurance coverage. *The SCMA MIT health and hospitalization programs, however, will remain the same with NO change in benefits. Claims will now be filed with Provident Life effective 2/15/85.*

The SCMA Council has expressed serious concern over Blue Cross and Blue Shield's "marketing" techniques and has filed a formal complaint with the South Carolina Insurance Commissioner.

The MIT will continue to provide health and hospitalization insurance as a member benefit and the Board has expressed the hope that SCMA members will support their program. *For information on the coverage offered, including the new age-banded rate structure, contact the SCMA at 798-6207.*

SCMA SUPPORTS CONCEPT OF MEDICALLY INDIGENT ASSISTANCE ACT

At its January meeting, the SCMA Council reviewed the Governor's Medically Indigent Assistance Act, and voted to support the concept of this legislation. The Bill has been referred to the SCMA Committee on Medicaid and Indigent Care for its study and comments. The Governor has been advised that the association offers its input and assistance in reviewing the Act's provisions. See this month's "*Legislative Update*" for additional information.

GUEST SPEAKERS: SCMA LEADERSHIP CONFERENCE

Guest speakers for the Leadership Conference to be held in Columbia on February 27, 1985 have been announced.

Representative David O. Hawkins, Chairman of the House Medical, Military, Public and Municipal Affairs Committee, will be the luncheon speaker. Speaking on current legislative issues and trends on the national level will be *Bruce D. Blehart*, Assistant Director of the AMA Department of Federal Legislation. *Robert Hitt*, Managing Editor of the Columbia Record will moderate the Media Relations Workshop.

Invitees who have not returned their registration cards should do so immediately.

NOT AT THE TOP -- BUT STILL CLIMBING

In the first three months of the 1985 membership campaign, SCMA has increased more than six percent in the active member category over the comparable period last year.

According to SCMA President, *Kenneth N. Owens, M. D.*, "the membership response is directly related to the recent positive accomplishments of the SCMA and the enthusiasm engendered by our long range program." "We expect this trend to continue," Dr. Owens added.

Response by Housestaff members is encouraging, and student leaders at both medical schools have embarked on a program to increase membership among medical students.

The American Medical Association also reports that its membership reached an all-time high for the year 1984 -- more than 4,000 over the previous year -- with the greatest gains in regular memberships.

MORE ANNUAL MEETING NEWS: SHERATON CHARLESTON HOTEL, APRIL 24-28, 1985

Since last month's "*Newsletter*," the scientific portion of the 137th Annual Meeting of the SCMA has been announced.

James Long, M. D., Chairman, and the SCMA Committee on Continuing Medical Education have planned and coordinated an excellent scientific assembly for 1985. Plenary Sessions will be held on Friday and Saturday mornings, April 26 and 27. Friday's topic will be "*Update in Endocrinology*," moderated by *Kay F. McFarland, M. D.*, and Saturday morning's topic will be "*Psychiatric Disorders in Primary Care Practice*," moderated by *R. Ramsey Mellette, M. D.*

The *Sports Medicine Symposium* will cover such topics as facial injuries and dermatological problems of athletes, and will feature former coach and present Athletic Director of Presbyterian College, *Cally Gault*, discussing guidelines for returning athletes to participation. A *Symposium on Pulmonary Medicine* is also scheduled and will be moderated by *J. Daniel Love, M. D.*

A *Risk Management Seminar* on Friday afternoon will feature the topics of *Family Stress in Relation to Medical Malpractice Lawsuits*, as well as a *Mock Deposition*.

Other workshops will be held Wednesday through Friday afternoons, and pre-registration for all scientific sessions is encouraged. AMA Category I Credit and AAFP Prescribed Credit will be awarded on an hour-for-hour basis.

All information and pre-registration materials have been mailed from SCMA Headquarters. Members are reminded that tickets for the SOCPAC luncheon, at which *James J. Kilpatrick* will be the featured speaker, are limited to 150, AND MEMBERS OF SOCPAC WILL BE GIVEN FIRST PREFERENCE FOR TICKETS.

PLAN TO ATTEND THE 137TH ANNUAL MEETING - PRE-REGISTER TODAY!

MEDICARE "PARTICIPATING" MDS

Nearly 30 percent of the nation's Doctors of Medicine and Doctors of Osteopathy elected to become "participating physicians" under Medicare, according to a detailed analysis by the Health Care Financing Administration.

HCFA reported in late January that 118,424 individual physicians or groups (29.8%) signed participation agreements. In all, there are 396,840 physicians who bill under Medicare.

The highest rate of participation (53.9%) among physicians is in Alabama. The lowest rate (5.6%) is in South Dakota. The participating rate among limited-license practitioners was 34 percent which included 19,571 of 58,125 such practitioners. Among suppliers, the rate was 23.8 percent. This includes 17,822 of the 75,014 Medicare suppliers.

HCFA noted that 65.6 percent of all claims submitted in November, 1984 were assigned. This is substantially higher than the November, 1983 rate of 52 percent.

STATUS OF AMA MEDICARE LAWSUIT

The freeze on physician reimbursement under the Medicare program has forced the nation into a two-tier system of medical care in which Medicare patients become "second-class citizens," the AMA said in a brief filed in U. S. District Court in Indiana. The AMA said it was challenging the Medicare provisions of the Deficit Reduction Act of 1984 because it "profoundly alters and dramatically enlarges the role of government in the delivery of health care." The AMA filed documents examining data on the causes of increased spending on health care. The documents state that "virtually all of (the increased spending) -- apparently over 95 percent -- is due to three factors: general inflation, increased Medicare enrollment, and increased utilization of physicians' services by Medicare patients.

In real economic terms, physicians' fees to Medicare patients have increased very slowly and average charges and reimbursements have been declining." The AMA said that "physicians' fees...measured in constant dollars have been growing by only 1.0 percent annually since the early 1970s," that physicians' real net incomes have been declining on average (by 0.2% a year), and that MDs' fees to Medicare patients "have grown no faster than other fees, and appear to have grown more slowly."

HCFA IMPLEMENTS NEW PAYMENT AND ADMINISTRATIVE POLICIES

On January 10, 1985, the Health Care Financing Administration published final regulations implementing the new payment and administrative policies affecting Medicare contracts with health maintenance organizations (HMOs) and competitive medical plans (CMPs). These rules follow the statutory changes agreed to by Congress in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA).

It is important to understand that these new Medicare "at risk" contracts represent a major structural reform in Medicare payment to providers. Permitting HMOs and CMPs to enroll Medicare beneficiaries at 95 percent of the Adjusted Average Per Capita Cost will strongly encourage the expansion of prepaid delivery systems. One need only look at the per capita payment rates published in the back of the Regulation to realize how strong the inducement will be, particularly in certain market areas.

(From AMPRA Bulletin, January 16, 1985)

DHEC BOARD CHANGES

SCMA President-Elect *Leonard W. Douglas, M. D.*, has resigned from the Board of Directors of the S. C. Department of Health and Environmental Control, effective January 31. Dr. Douglas served on the board for nearly 11 years and was Vice Chairman when he resigned. Dr. Douglas will assume the Presidency of the SCMA in April, and his election to this leadership role was a major factor in the decision to resign, along with increasing demands of a busy family practice.

DHEC Commissioner, *Robert S. Jackson, M. D.*, expressed his regret over Dr. Douglas' resignation on behalf of the agency and its employees. "His considerable contributions to the board and the agency will be missed without question," said Dr. Jackson. *Moses Clarkson*, Chairman of the DHEC board, observed that Dr. Douglas brought a special insight to the deliberations of the board with his background as a physician.

Of special note is the fact that another physician will replace Dr. Douglas on the board. Governor *Richard W. Riley* has appointed, and the Senate has confirmed, *Euta M. Colvin, M.D.*, a former President of the SCMA, and presently Chairman of the Board of SCIMER and Chairman of the SCMA Professional Liability Committee.

In commenting on Dr. Colvin's appointment, Dr. Douglas said, "It was a privilege for me to recommend Dr. Colvin to Governor Riley. The Governor holds Dr. Colvin in very high esteem and has been an acquaintance of his for a number of years. As an officer in the SCMA, I have worked very closely with Euta. Having served on the DHEC board for an extended period of time, I know the importance of very deliberate decisions and the great amount of time that is required to serve. Dr. Colvin is a very thoughtful and concerned citizen as well as a physician in this state, and he will serve the board and the Department extremely well."

CAPSULES...

..... Honorary membership status has been granted the following loyal SCMA members: *E. C. Kinder, M. D.*; *William Hamilton, M. D.*; *Dana C. Mitchell, Jr., M. D.*; *Rudolph H. Hand, M. D.*; *L. Charles Bailes, M. D.*; *Henry Ross, M. D.*; *Casper E. Wiggins, M. D.*; *D. Strother Pope, M. D.*; *Harold Miller, M. D.*; *Edward F. Parker, M. D.*; and *J. Manly Stallworth, M. D.*.....

.....*John Brown, M. D.*, *Columbia*, has been appointed to the Advisory Council of the Division of Emergency Medical Services of DHEC, as SCMA representative to replace *Edmund R. Taylor, M. D.*, who recently resigned after many years of service.... SCMA representatives to the New Technology Task Force of the Statewide Health Coordinating Council will be *John Thomas, M. D.*, *Columbia Radiologist*, and *Thomas Kirkland, M. D.*, *Charleston Urologist*.....

SOC PAC/AMPAC MEMBERSHIP

Recent reports from the American Medical Political Action Committee indicate that South Carolina ranks in the first 10 nationwide of PAC members who are also members of the AMA, with a total of 28 percent of AMA members joining the PAC. Meantime, membership in SOC PAC/AMPAC in 1985 has been most gratifying. In recognition of dedicated giving to political actions, members will soon be receiving their 99+ lapel pins as Sustaining Members in AMPAC and SOC PAC.

THE MEDICAL THERAPY OF ANGINA PECTORIS — WITH AN EYE ON COST

KENNETH H. HANGER, JR., M.D.*

The author and The Journal Editorial Board express grateful appreciation to CIBA Pharmaceutical Company which generously funded the publication of this article.

Death from coronary artery disease, despite its decline from 1968 to 1976 of 21 percent,¹ is still the leading cause of death in the United States. In fact, in 1969, 29 percent of all deaths in the United States were cardiac related. This disease is devastating because it kills and disables people in their most productive years and accounts for nearly \$10 billion annually spent on cardiovascular services. Two percent (four million) of Americans have coronary heart disease, half below age 65. There are over 500,000 heart attacks each year with one in five American males to develop this disease before age 60.² Often the presenting complaint in women is angina, while in men sudden infarction or sudden death are commonly found. Thus this disease represents a major challenge still facing the modern world despite new awareness, risk modifications, coronary care units and medical and surgical therapy.

Angina pectoris is a symptom of coronary artery disease described by Heberden as a "sense of strangling and anxiety . . . a painful and most disagreeable sensation in the breast . . .".³ Angina pectoris results from a complicated series of events, a series that we are still attempting to unravel. Most commonly fixed atherosclerotic coronary artery disease is the underlying cause in most patients with angina pectoris, however, there are other causes (Table I). A simple approach towards the pathophysiology of angina invokes a supply and demand scheme to describe the events that cause myocardial ischemia and thus pain.

What is threatened is the nutritional supply of myocardial cells. Their *demand* for nutrition (oxygen, glucose, ATP, etc.) are generally governed by the following factors:

1. Heart rate
2. Afterload (systemic vascular resistance or more easily determined, blood pressure)
3. Preload (in simple terms, the filling pressure of the ventricle)
4. Contractility

The *demand* for myocardial nutrients, in angina, is not able to be met by the *supply* of nutrients. The "supply side" is generally affected by⁴

1. Fixed atherosclerotic disease of the coronaries,
2. Coronary artery spasm, and
3. Platelet deposition and thrombus formation.

Thus it is believed that an imbalance of the supply and demand accounts for the occurrence of myocardial ischemia and angina pectoris. Therapy is directed towards correcting this imbalance. (Table II.)

Generally the medical therapy of angina also includes risk factor reduction such as weight reduction, stop cigarette smoking, lessen stress,

Table I
DISEASES THAT MAY UNDERLIE ANGINA PECTORIS¹²

Coronary Artery Disease
Atherosclerotic luminal narrowing
Non atherosclerotic diseases
Coronary artery spasm
Congenital coronary anomalies
Coronary thrombo-embolic events
Coronary artery vasculitis
Valvular Heart Diseases
Aortic stenosis or insufficiency
Mitral valve prolapse or stenosis
Pulmonic stenosis
Hypertrophic cardiomyopathy
Other (hypertension, normal coronary arteries with no identifiable disease)

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THERAPY OF ANGINA PECTORIS

Table II
MEDICAL THERAPY OF ANGINA PECTORIS

	SUPPLY		DEMAND			
	Vasospasm	Fixed Lesion	Heart Rate	Contractility	Preload	Afterload
Nitrates	↓ ↓	—	— ↓	— ↓	↓ ↓	↓
Beta Blockers	—	—	↓ ↓	↓ ↓	—	— ↓
Calcium Blockers	↓ ↓	—	↓ —	↓ —	—	↓ ↓

lower elevated cholesterol levels and control hypertension and diabetes. Then three major groups of medicines are used in addition, consisting of nitrates, beta blockers and calcium channel blockers to control symptoms of angina.

The nitrates have been used to treat angina for over a century. Their points of attack are several. Nitrates can do the following to reduce myocardial ischemia:

1. Relieve coronary spasm (*supply*)
2. Dilation of collateral blood vessels (*supply*)
3. Dilation of atherosclerotic areas of narrowing (*supply*)
4. Redistribution of flow to subendocardium (*supply*)
5. Reduce afterload (*demand*)
6. Reduce preload (*demand*)

Nitrates produce vasodilatation by two mechanisms in vascular smooth muscle. One mechanism is by promoting the production of cyclic GMP (guanosine 5', 3' monophosphate) which then affects calcium influx into the cell. Another is the ability to promote prostacyclin formation which again affects vasodilatation.⁵

Nitrates are generally the most inexpensive of the three types of antianginal medications. Sublingual nitroglycerin is rapidly absorbed and has an onset of action within two to five minutes. Longer acting nitrates come in various forms. Two percent nitroglycerin ointment has sustained action for four to six hours. Unfortunately, this preparation is sometimes messy. Oral and sublingual isosorbide dinitrate also have sustained action, the sublingual form from two to four hours and the oral form from four to six hours.⁶ Recently the transdermal sustained release discs have been met with great popularity.⁷ Their attractiveness is their ability to sustain action for 24 hours with a pleasant delivery vehicle and this has produced

sales of over \$150 million in the last two years. Unfortunately, little clinical efficacy was proved prior to their release and now increasing reports^{8, 9} have scientifically deduced that it often takes very large doses (25 mgs. or more per day) to sustain effectiveness. Thus, in terms of cost, it becomes very expensive to be clinically effective. More data are needed before this form of therapy can be better quantitated in terms of the dosage needed for patients.

Nitrates in general have several drawbacks, mainly from side effects. Headaches are common, but usually diminish after continued use. Dizziness and light-headedness also are not uncommon. Nitrate tolerance is becoming more important and probably plays an important role in the lack of sustained action of 24-hour discs.

The beta blockers have been used for two decades in the treatment of angina pectoris. They can be divided into non-selective and selective agents.¹⁰ Non-selective drugs block both subgroups of beta receptors at approximately the same dose and decrease heart rate (*demand*), lower contractility (*demand*), and thus decrease oxygen consumption. Cardioslective drugs block beta₁ receptors and not beta₂ receptors and are less likely to induce bronchospasm and claudication. This advantage is lost at higher doses. There are other distinguishing factors of the beta blockers including lipid solubility (long or short acting), membrane stabilizing activity (quinidine-like effect at levels well above therapeutic) and presence of intrinsic sympathomimetic activity. (Table III.) Overall, the beta blockers' clinical efficacy has been well proven and combined with the use of nitrates, have been the mainstay of anginal therapy until the arrival of calcium channel blockers two years ago.

Beta blockers also have drawbacks. Congestive heart failure, heart block, asthma and peripheral vascular disease are all relative contraindications.

THERAPY OF ANGINA PECTORIS

Table III
PROPERTIES OF BETA BLOCKERS

	<i>Duration of Action</i>	<i>Cardioselectivity</i>	<i>Membrane Stabilizing Activity (MSA)</i>	<i>Intrinsic Sympathomimetic Activity (ISA)</i>
1. Propanolol	Short	—	++	—
2. Metoprolol	Short	++	+-	—
3. Nadolol	Long	—	—	—
4. Timolol	Short	—	—	—
5. Atenolol	Long	++	—	—
6. Pindolol	Short	—	++	+++

Depression, nightmares and impotence are not uncommon. Thus these drugs need to be tailored to each patient's need.

The newest group of antianginal drugs are the calcium channel blockers. Three currently available drugs all act slightly differently but have as their end point the manipulation of calcium movement in smooth muscle cells and in the myocardial conduction system. Calcium channel blockers can produce coronary artery dilatation (supply), reduce blood pressure (*demand*) and lower heart rates (*demand*).¹¹ Nifedipine is the most potent vasodilator and has little effect upon either conduction or contractility of the myocardium. Diltiazem is not as potent a vasodilator but has more effect upon conduction (it can cause a resting bradycardia and occasionally heart block) and can decrease contractility. Verapamil is the least potent vasodilator and the most likely to induce heart block (thus its efficaciousness for paroxysmal supraventricular arrhythmias by suppressing conduction through the AV node) and heart failure in patients with reduced contractility.

All of these drugs can cause side effects such as dizziness, headaches, gastrointestinal problems and edema. Again, drug choice depends upon the individual receiving therapy.

Table IV presents a survey of three pharmacies in the Florence area to obtain a "feel" one might get for the average cost of some of the antianginal medications that have been previously described. Based upon these figures and with the knowledge of the patient's history, physical examination and laboratory data, one can begin to develop a "cost conscious" approach to antianginal therapy. However, these are merely suggestions and the patient's needs should be considered and therapy individually tailored to fit these needs. Therapy should be flexible enough to meet changes in the patient's activities and changes in the activity of the disease process itself.

Nitrates still remain the first choice in the treatment of angina pectoris. They are inexpensive and effective. Here only the delivery system needs questioning. Nitroglycerin ointment is inexpensive but as noted previously, can be messy. Discs can be effective but perhaps are only effective in very high dosages and may need a thrice daily dosage. If the patient doesn't like the ointment form, then cost-wise isosorbide dinitrate is the next effective form. In fact, the generic form of this is about one-third of the price listed in Table IV and thus is equal to nitroglycerin ointment. If one starts with a transdermal patch, start with a "high" dose, say 10 to 15 mgs. per twenty-

Table IV
REPRESENTATIVE COSTS OF VARIOUS ANTIANGINAL MEDICATIONS*

	<i>Drug Store A</i>	<i>Drug Store B</i>	<i>Drug Store C</i>	<i>Average</i>
1. Nitroglycerin ointment, 1" q.i.d. 60 gm tube	\$ 6.68	\$ 9.75	\$ 8.41	\$ 8.28
2. Isosorbide Dinitrate (Isordil) 20 mg. q.i.d.	20.50	22.85	22.35	21.90
3. 10 mg nitro disc (Transderm) t.q.d.	31.19	37.95	38.09	35.74
4. Verapamil (Calan) 80 mg. t.i.d.	23.58	25.59	24.28	24.48
5. Nifedipine (Procardia) 20 mg. t.i.d.	45.08	33.58	32.43	37.03
6. Diltiazem (Cardiazem) 60 mg. t.i.d.	31.39	38.25	38.85	36.16
7. Propanolol (Inderal) 20 mg. q.i.d.	17.30	19.25	17.63	18.06
8. Atenolol (Tenormin) 50 mg. q.d.	13.62	15.49	14.39	14.50

* Prices are cost to patient, quoted on January 7, 1985 for one month's supply.

four hours. If there is no clinical response consider adding on another type of medicine or changing to another type of nitroglycerin. A patient with side effects needs to be changed to another type of antianginal medication.

When the patient is still symptomatic on nitrates then another drug needs to be added. In patients with contraindications to beta blocker therapy (asthma, heart failure, claudication) a calcium channel blocker would be necessary. A calcium blocker that tends to decrease contractility or lower heart rate such as diltiazem or verapamil would make for an excellent combination. However, verapamil should not be used in a patient with congestive heart failure symptoms. Patients without contraindications to beta blockers would benefit from beta blockade in addition to nitrates. A once daily beta blocker such as atenolol certainly would be cost effective and also promote compliance. The combination of nitrates and beta blockers still forms a cost effective team against angina in patients that can tolerate both.

However, if angina persists or the patient has side effects from beta blocker therapy, then calcium channel drugs can be safely added. These drugs are not generally considered first line drugs (the only exception being a patient with coronary artery spasm or a patient intolerant to nitrates). Again with an eye on costs, if a beta blocker can be used as a "second-line" drug, then costs are kept down as the calcium channel blockers are the most expensive of the antianginal drugs. Each of the calcium channel blockers has its advantages and disadvantages. Nifedipine is the most potent and expensive but also can cause side effects frequently. Verapamil is the least expensive, fits best the patient with tachyarrhythmias and angina, but as noted previously, can worsen heart failure. Diltiazem also is fairly expensive, but seems to have the fewest side effects. These drugs in general are adding a new and exciting dimension to treating angina pectoris.

What if your patient still has angina on "triple therapy" i.e. nitrates, beta blockers and calcium channel blockers? What this paper purposely stayed away from is the role of angiography, stress testing, coronary artery bypass grafting and angioplasty. A recent review¹² is excellent and addresses these issues. Needless to say, the recent Coronary Artery Surgery Study (CASS)¹³ found that during the use of beta blockers and nitrates,

medical and surgical mortality *in general* was low without significant differences, although a trend towards better surgical survival was found in patients with depressed left ventricular function and three vessel coronary artery disease. There are some important limitations to this study, but overall it suggests that medical therapy will continue to play an important role in the treatment of angina pectoris.

In summary, the three types of antianginal medications all have their strengths and weaknesses. Discerning each patient's particular problems and needs, knowing about costs and being aware of what the medications have to offer makes the best combination in not only being cost effective, but also in bringing about a successful treatment approach to angina pectoris. □

ACKNOWLEDGEMENT

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Editorials

The following is the sixth in a series of editorials on diagnosis related groups (DRGs).

— CSB

THE EFFECT OF DRGs ON OFFICE PRACTICE

Public Law 98-21, the Prospective Payment System for Hospitals, in October, 1983, instituted the diagnosis-related group (DRG) classification and reimbursement system for payment of Medicare patients while in the hospital. There have been numerous articles published and much speculation on the outcome of this system in regards to the economic survival of hospitals and the effect eventually on other parameters of medicine. However, very little has been said about the effect of the DRG system upon the outpatient office practice of physicians and, indeed, a recent search of the literature failed to uncover any published articles in this regard.

One would probably immediately assume that the initial effect would be acceleration of outpatient volume, profits and malpractice risks.

The system obviously rewards hospitals who are able to discharge patients more rapidly and those who have had less use of ancillary services and expensive therapies. It is conceivable that patients then may have some of these diagnostic tests and even treatment modalities performed on a pre- and post-hospital basis in the office rather than in the hospital. Physicians now have most of the highly technical diagnostic equipment available in their offices and can perform the same tests as the hospital at a lower rate because of less overhead. The unit cost of such procedures would be less than hospital costs to the payer and has become increasingly popular among insurance companies who formerly required patients to be in the hospital to insure payment for such testing. Also, it is more rewarding from a diagnostic aspect and generally more pleasant for the patient to perform certain procedures (such as ambulatory arrhythmia monitoring) in the patient's usual environment and with him actually at work, which has definite appeal to industry on work days lost due to illness.

The above illustrations indicating extensive use of physician facilities and diagnostic equipment would obviously increase his profits as would the

ability to see patients in his office, an environment more conducive to effectively handling a high volume of patients in a given unit of time rather than traveling floor to floor in the hospital and trying to "catch" patients between hospital routine procedures.

Since over seventy percent of physicians are participating in the voluntary freeze on their fees in a time of continuing inflation, higher productivity would be one means of maintaining adequate economics without sacrificing high quality academic care. It is also usually more cost effective for patients to obtain their medications through their own pharmacies or organizations which offer generics at a lower cost than the hospital fees for the same medications.

Unfortunately, a large segment of our society believes that the only acceptable way to expire is in a hospital bed. It appears that the wave of the future in medicine will be toward more outpatient care and less inpatient days which will require a great deal of education to the general public. Quality of life will necessarily have to be stressed, and particularly with our aging population, who are most reluctant to end their active life styles by being put in a "protective environment" for the peace of mind of their relatives. Medicine must be prepared for its role of leadership in accomplishing these goals and should encompass the cooperation of the legal profession to afford a system of sound and practical academic treatment and eliminate the "economic gamesmanship" occasionally seen in malpractice suits.

The effect of DRGs on office practice will also be markedly manifest from a medical education aspect. Tertiary-care teaching hospitals stand to be the biggest losers on a payment pattern and need to promptly foster training of medical students and residents in more efficient outpatient care. Usually physicians who have completed training enter private practice with the primary notion of treating illnesses inside a hospital setting, with very little experience or even inclination in

treating the same patients in their offices. It will become increasingly obligatory to change these teaching patterns to accurately reflect changing trends in medicine as a specific tool in cost effective management.

It would be remiss not to point out that the medical profession has an urgent need to take a leadership role of the developmental process of

the DRG system and to remember that the speed of legislation and implementation allow no time for bemused reflection.

E. CONYERS O'BRYAN, JR., M.D.
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OF COST-CONTAINMENT AND CAT-BELLERS

Reprove not a scorner, lest he hate thee: rebuke a wise man, and he will love thee.

— Proverbs 9:8

A prerequisite for worthwhile evaluation . . . is for all doctors to cultivate a self-critical attitude to their practices. The authoritarian natures of medical practice and medical knowledge tend to stifle criticism. . . .¹

— Lancet 2: 77-78, 1984

In this issue of *The Journal*, Dr. Conyers O'Bryan of Florence has both edited a symposium on cost-effective cardiovascular drug therapy and also written the preceding editorial on the implications of DRGs for office-based physicians. In next month's issue, Dr. Mims Mobley of Greenwood will provide the last of our planned series of editorials on DRGs, conceived during 1983 and begun a year ago. We can anticipate that dialogue regarding these two topics — cost-effective therapy and the implication of DRGs — will continue to appear in these pages for years to come. In the meantime, Dr. O'Bryan points out that although DRGs may seem to cloud the future of medical practice, there may be at least one silver lining: incentive for high-volume, cost-effective outpatient medical care.

The delivery of a greater proportion of medical care in outpatient settings will spawn predictable attempts to extend the concept of DRGs to those settings. We have already been told that the Department of Health and Human Services plans to extend the DRG approach to ambulatory care.² Like it or not, the issue of cost-effectiveness in all of what we do is here to stay.

The percentage of our gross national product spent on health care delivery more than doubled during the past 25 years. During this period, leaders of our profession frequently sounded the need for cost containment and for medicine to "maintain its own house." Why did these cries fail to

bring about effective self-regulation long before the enactment of PL 98-21 in October, 1983? Were our leaders ineffective?

I suggest that our failure to bring about cost control prior to the recent legislation was due not to lack of leadership but rather to the nature of the problem. Talented persons from many areas — organized medicine, academic medicine, practicing physicians, and the lay public, to name a few — addressed the issues both frequently and forcefully. However, the problem was analagous to that facing the wise mouse of the fable who proposed placing a bell around the cat's neck. Who was to actually bell the cat?

Our attempts to promote cost-effectiveness were stymied by at least two factors. The first of these is the failure of society to provide us with a suitable ethical and legal framework upon which to base decisions, in part, on cost-effectiveness issues. As patient advocates, we understandably feel the frequent need to do "everything possible" even when the cost-potential benefit ratio seems exceedingly high. The second factor is human nature, which poses powerful barriers to truly effective peer review. Knowing that our fellow physicians — like most other people and like even ourselves — sometimes tolerate criticism poorly, we are usually reluctant to give it. We therefore keep to ourselves our opinions that some of our colleagues could practice medicine in a much more cost-effective manner.

As individuals, we cannot bell the cat ourselves. We need society's advice and consent regarding the extent to which we can base clinical decisions upon estimates of cost-effectiveness. We need our profession's help to provide the data for making these estimates. As a recent editorialist put it:

"It will be far better (compared to a complicated set of rules and regulations) if American doctors begin to build up a social ethic and behavioral practices that help them decide when medicine is bad medicine — not simply because it has absolutely no payoff or because it hurts the patient — but also because the costs are not justified by the marginal benefits."³

We must encourage the development, both on a national and local basis, of effective guidelines

upon which to base such judgments. We must encourage the development of more effective quality assurance and peer review activities at our hospitals. We must become more self-critical and more willing to give criticism to others and accept their criticism in turn.

A new mind-set for medical practice (code name: cost-effective medicine) must support and supplement the old one (code name: scientific medicine). We must all become cat-bellers.

— CSB

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1984 JOINT NATIONAL COMMITTEE RECOMMENDATIONS ON DETECTION, EVALUATION AND TREATMENT OF HIGH BLOOD PRESSURE

In 1984, the Director of the National Heart, Lung and Blood Institute reestablished the Joint National Committee (JNC) on Detection, Evaluation and Treatment of High Blood Pressure to advise the National High Blood Pressure Education Program on issues of hypertension management and control. They were charged with reviewing the 1980 JNC report and with reaching a consensus on guidelines for practicing physicians and other health professionals participating in high blood pressure control programs across the nation.

Under Dr. Harriet Dustan's leadership, the Committee developed recommendations on a variety of management problems and questions relative to hypertension control. Key areas addressed by the Committee include: screening and referral procedures; classification of blood pressure levels; use of nonpharmacologic therapies for reducing risk factors; revised stepped-care approach; management of mild hypertension; management of special populations (such as black patients, children, and pregnant women); and patient-profes-

sional interaction. In addition, the Committee has reviewed and revised the listing of available anti-hypertensive agents, their dosages, side effects, and special considerations for use. Substantial information was developed to guide practitioners in the management of hypertensive emergencies.

Additional information about these recommendations or a copy of the JNC Report can be obtained by contacting the Division of Chronic Disease, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, S. C. 29201 (telephone: 803/758-0338).

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LETTER TO THE EDITOR

To The Editor

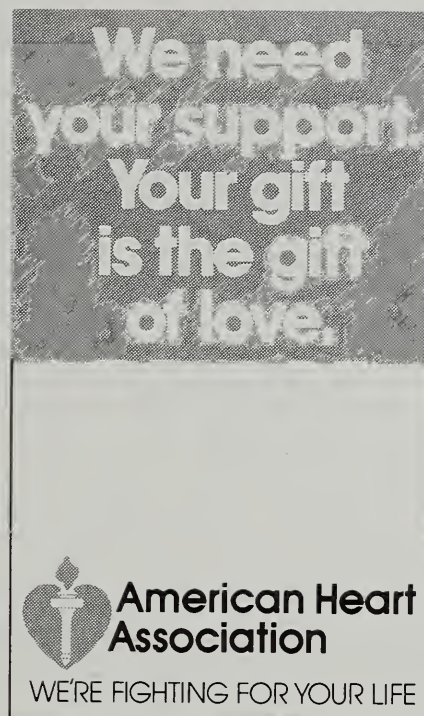
On behalf of the S. C. Diabetes Control Project, I want to thank you and your staff for your assistance in the publication of our editorial about the *Diabetes Guide (The Prevention and Treatment of Five Complications of Diabetes: A Guide for Primary Care Practitioners)*. As a result of the editorial, we have received a number of requests for copies of the *Guide*, and we are most appreciative of your *Journal's* effectiveness in reaching the practitioners for whom the *Diabetes Guide* was intended.

Many thanks for your help — we look forward to working with you again. Have a happy holiday season.

FRANCES C. WHEELER, PH.D.,
Director

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**ON THE COVER:
CORNELIUS KOLLOCK, M.D.
1824-1897**

The year 1887 was a relatively comfortable and peaceful time for South Carolina physicians, as compared to the "reconstruction" period of only 20 years earlier. Cornelius Kollock, M.D., who served in the Confederate War, described that conflagration as being fought "to gratify the passions of a set of whimpering philanthropists and bring political aggrandizement to unprincipled and designing demagogues."

Physicians returning home after Appomattox found the aftermath of war a dreary specter indeed. Stagnant and scorched countryside led to cities and desolation and ruins. Columbia was described as a "wilderness," with its "heart a mass of blackened chimneys and crumbling walls." Charleston was a place of widowed women, weed-wild gardens, grass-grown streets, vacant houses, rotting walls and acres of pitiful barrenness.

In Charleston, a returning doctor reported that he was "living in two rooms where I made my own fires, helped cook and trudged around on foot for a year to get a bone at market or a scant loaf of bread that served our frugal meal." Another doctor said, "I am doing little or nothing. Proprietors and freedmen alike seem averse to paying physicians' accounts."

Cornelius Kollock, M.D., served as President of the South Carolina Medical Association in 1887. Two topics important to the medical association occurred under Dr. Kollock's tenure. The SCMA recommended to the South Carolina Legislature that appointments to the Board of Medical Exam-

iners be made by our association. This recommendation met with partial acceptance. Also, during that session, a new Code of Medical Ethics was added to our Constitution, advising physicians to "unite tenderness with firmness" and avoid "gloomy prognostications. Patients," it recommended, "were advised to select qualified physicians of regular habits who were not devoted to pleasure."

Cornelius Kollock, M.D., was born December 7, 1824 near Cheraw, South Carolina. He attended Cheraw Academy, Brown University, the University of Pennsylvania Medical School, and did two years of postgraduate training in Paris. Dr. Kollock began his medical career in Cheraw, S. C., in 1851. In addition to his large and successful rural medical practice, Dr. Kollock made significant contributions to obstetrics, becoming the first physician in his section of South Carolina to use obstetrical forceps. He and his wife, Mary Shaw of Boston, had four children, one of whom, Charles W., became a "distinguished oculist and aurist" in Charleston.

Until his death following several "strokes" on August 17, 1897, Cornelius Kollock, M.D., was actively involved as a charter member in the Cheraw Masonic Temple and Senior Warden of Saint David's Episcopal Church in that city. His rector lamented at his death, "Truth in thought, word and deed was the ground-work of his character as uprightness was of his life."

— THOMAS M. LELAND, M.D., Ph.D.

FINANCIAL CHECKUP

MARTIN LEFKOWITZ
Certified Financial Planner
Tax Shelter Co-Ordinator: E.F. Hutton

Vol. 4, Issue No. 2

February 1985

FOR MANY HAPPY RETURNS, CONSIDER CONVERTIBLE SECURITIES

If you are looking for a way to play the market this winter without catching cold, convertible securities may be the answer.....A convertible is an investment security that can be converted into shares of common stock. It does not matter whether the convertible is issued as a preferred stock or bond - it can, at a specified price, be exchanged for shares of the underlying common.....At the same time, convertibles generally offer higher yields than their stock price changes. And with today's declining interest rates, the yields on many convertibles are especially attractive. In fact, even investors more accustomed to certificates of deposit, bonds or utility stocks might find convertibles appealing. And today's higher yields should also provide downside protection should the common stock drop in price.....There are three definitions you should know when considering this hybrid investment:

*Conversion ratio - The number of common shares into which the convertible can be exchanged.

*Conversion value - The value of the common shares represented by the convertible based on current prices.

*Conversion premium - Also known as the premium-over-conversion value, this is the percentage by which the convertible's price exceeds its conversion value. Issues with low conversion values tend to follow the price movement of the underlying common much more closely than issues with higher conversion premiums, say over 25% which tend to mirror changes in interest rates rather than the common.

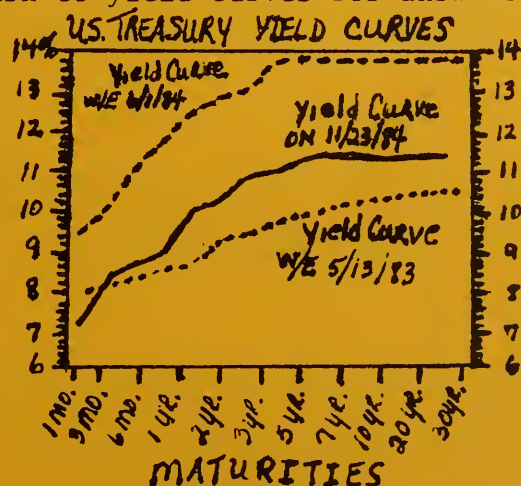
For a more complete picture of convertible securities, ask me to send you a more detailed description.

TURN TO YIELD CURVES FOR ANSWERS

Can't decide whether to commit your money to a long-term investment and lock in a current interest rate or go short-term in the hope that interest rates may be even more favorable in the near future? Turn to yield curves for answers.

The chart on the right shows three yield curves, which indicate interest rates at various maturities of U.S. Treasury securities. As you can see, the top two curves reflect the downward movement of interest rates after their apparent peak at the beginning of June.

Just as important as the perceived downward movement of interest rates is the yield curve's "sharpness," which indicates how wide the disparity is between short- and long-term rates. In May 1983 there was only a 2.2 percent spread between the rates of the shortest and longest terms.



SUMMARY OF BROKER FIRMS REPORTING FOR CLIENTS TO THE IRS.

Each year, Broker Firms are required to report certain client information to the Internal Revenue Service.....In an effort to clarify what information will be and has been reported to the IRS, as well as provide you with a guide on what information the IRS expects from clients, I offer the following summary.

SALES PROCEEDS REPORTED TO IRS.

Each firm is required to report to the Internal Revenue Service the amount of each 1984 sale transaction.....Bond sale net amounts reported to the IRS will exclude accrued interest received. Each firm is required to report accrued interest separately as interest income to the seller. You should subtract accrued interest from the amount reported in the net amount box in order for you to match the amount your firm must report to the IRS. Accrued interest received on municipal bonds is not taxable, and Firms are not required to report such interest to the IRS.

INCOME REPORTED TO IRS.

Your broker is required to report to the IRS your 1984 income, if it is greater than \$10. In previous years, the December statement was sent as your report of income for the year. This year, all brokers are required to send you a Form 1099 in addition to your year-end statement. The Form 1099 should show the dividend amount, a combined interest amount, which includes corporate and government interest, accrued interest received and short-term original issue discount (OID).....It is recommended that a client who holds an OID obligation, obtain a copy of Internal Revenue Service Publication 1212, "List of Original Issue Discount Obligations," and IRS Publication 505, "Investment Income and Expenses." There may be instances, because of IRS prescribed methods of calculating OID, when there may be differences from what your broker is required to report to the IRS and your actual income. I recommend that you refer to your tax consultant for further direction.

EXCLUDABLE DIVIDENDS.

Dividends from Money Market Cash Funds are not eligible for the \$100 dividend exclusion (\$200 for joint returns) or the 85 percent dividend received deduction for federal income tax purposes.

WITHHOLDING TAX CREDIT.

Backup withholding effected on dividend or interest income, or sales proceeds is not an additional tax. The tax liability of those persons subject to backup withholding will be reduced by the amount of tax withheld. If withholding results in an overpayment of tax, a refund may be obtained. The amount of tax withheld on dividend and interest income, and sales proceeds probably can be obtained in summary on Form 1099 for dividend and interest, or the December statement for sales proceeds.

FURTHER INFORMATION

If you would like to receive further information on any of the topics covered in this newsletter, please write to Martin Lefkowitz, CFP, E.F. Hutton & Company, 2700 Middleburg Drive, Suite 200, Columbia, SC 29204; or Call (800) 922-1112.

* * * * *

The information contained herein has been obtained from sources believed reliable but is not necessarily complete and cannot be guaranteed. Any opinions expressed are subject to change without notice. Neither the information presented nor any opinion expressed constitutes a representation by us or a solicitation of the purchase or sale of any securities. South Carolina Medical Association and E.F. Hutton & Company, Inc. 1985.

BOOK REVIEW

The AMA and U. S. Health Policy Since 1940.

F. D. Campion. Chicago Review Press. 604 pages. Illustrated.

This is to recommend strongly the recently published history, *The AMA and U. S. Health Policy Since 1940*. Not only is it entertainingly written and authoritative; it is must reading for every physician who is interested in knowing how our medical system developed the way it did and who shares a concern for preserving its quality in the years to come.

Written by Frank D. Campion, a former LIFE magazine editor who has been a member of the AMA staff since 1970, *The AMA and U. S. Health Policy Since 1940* is an authorized history that offers behind-the-scene views of how the AMA and American medicine became politicized, of what triggered the founding of the American Medical Political Action Committee, of what happened inside the AMA after Medicare was enacted, and of how the AMA avoided financial collapse in 1974. The book is published by Chicago Review Press and may be ordered through local bookstores.

Among events recalled are the downfall of the formidable Morris Fishbein, M.D., Editor of the *Journal of the American Medical Association* from 1924 to 1949, the dismissal of F. J. L. Blasingame, M.D., Executive Vice President of the AMA from 1958 to 1968, and the internecine battles within medicine over government interventions into medicine. Those moves began as early as 1943, when New York Sen. Robert F. Wagner introduced a bill to provide medical and hospital benefits through Social Security, and continued through the 1950's, when more and more funding for medical research came from government sources, and the 1960's, when Medicare and

Medicaid legislation was enacted. Practicing and academic physicians often took different positions on the issues, and the debate frequently spilled out of the AMA House of Delegates and executive offices. Debate continues into the 1980's over government-sponsored programs such as the Diagnostic Related Groups (DRGs) method for prospective pricing of Medicare recipient hospital costs.

"This book is a real insider's look at the medical profession," James H. Sammons, M.D., Executive Vice President of the AMA, has said. "It records our years of struggles, and it vividly recalls the many medical triumphs that have brought organized medicine to where it is today."

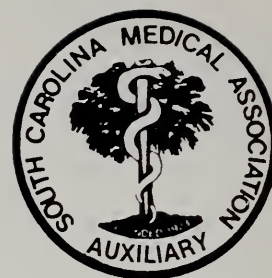
"Anyone interested in health policy in the U. S. should read this book," says Wilbur J. Cohen, Professor of Public Affairs at the University of Texas and former Secretary of the U. S. Health, Education and Welfare Department (now Health and Human Services).

Washington columnist Charles L. Bartlett adds, "I was intrigued by the crisp, clear and credible account of some of the most pivotal policy battles in our postwar history."

Booklist, a publication of the American Library Association, says this authorized history has several advantages over other books on the AMA, including timeliness and access to ample sources: "Anyone seeking information about, or understanding of, the AMA in the last 40 years will want this valuable book."

KENNETH N. OWENS, M.D.
President, SCMA

SOUTH CAROLINA MEDICAL ASSOCIATION AUXILIARY



AMA — ERF

For more than 30 years, dedicated individuals have contributed to the American Medical Association Education and Research Foundation (AMA-ERF) in an effort to ensure quality medical education. Virtually all of the contributions have come from caring medical families and were raised in large part by members of the American Medical Association Auxiliary. The AMA-ERF has three funds to which you may choose to contribute and specify a school of special interest to you as recipient.

The AMA-ERF Medical School Excellence Fund permits the Deans to use discretion in utilizing these funds which are not included in the schools' budget.

The AMA-ERF Students Assistance Fund is designed to provide financial assistance for medical students in their pursuit of quality education.

The AMA-ERF Unrestricted Fund is the only fund available to the Foundation's Board of Directors to respond to special health and medical programs, research and to provide emergency grants.

Here in South Carolina, two checks were presented to each of our medical schools last year at state convention. The grant total of the four checks presented through AMA-ERF was \$17,091.66. These funds were greatly appreciated by both schools as they had not been included in their budgets.

The South Carolina Medical Association Auxiliary has set the monetary goal for 1984-1985 auxiliary year at \$27,689.00 which represents a 25 percent increase over last year as suggested to all states.

We have undertaken two statewide fund raising projects. The first is the sale of aprons, gray with a mauve and blue pineapple stencil and natural with gold and green pineapple stencil. The second is the sale of two sets of tickets, one for a gold bracelet and one for a wildflower cross-stitched quilt. The drawings for these will be held at convention in April, and the monies designated to either of the two South Carolina medical schools.

As state chairman for AMA-ERF, I would like to say "Thank-You" for your generosity and support in the past and heartily encourage you to continue. Your donations are tax deductible; AMA-ERF is classed by Internal Revenue Service as a 501 (c) (3) organization, and gifts are considered charitable to a public foundation.

Of all the many worthy causes to which you donate, few can equal AMA-ERF in providing such important benefits to the people of our great state and country.

MRS. THOMAS C. LITTLEJOHN, JR.
Newberry, S. C.,
State AMA-ERF Chairman

President's Page



AM I MY BROTHER'S KEEPER?

The Council of the South Carolina Medical Association, at our last meeting, was privileged to receive a report from George Grimball, M.D., Chairman of our Impaired Physician's Committee. In addition, there was an insert in the January *Journal of the South Carolina Medical Association* relative to the committee's activities.

A plea was made to all members of Council to widely disseminate the fact that the committee feels confident of their ability to assist physicians who are impaired by the use of drugs, alcohol or any other chemical which serves to compromise their ability to function properly. The request is that anyone who knows any physician suspected of inappropriate usage of any substance should report this verbally or by written communication to any member of the Impaired Physician's Committee or to Mr. Bill Watson or Mrs. Pat Healy at SCMA Headquarters (798-6207). The members of this committee will receive the information and make every effort to contact and establish rapport with the involved individual. It is imperative to receive this information before any notification of the State Board of Medical Examiners, because once the Board becomes involved, there is generally insufficient time to allow for establishing the necessary rapport before the Board, through the Disciplinary Commission, has already acted.

We are our "Brother's Keeper." We have an obligation to any of our peers who *withdraw from (1) community and (2) family; (3) change jobs, often frequently; (4) demonstrate deterioration of their physical state; (5) no longer function effectively at the office or (6) hospital;* and we are obligated to communicate these facts to this very effective committee. Do this now; allow the committee to begin the process of rehabilitation before there is the very painful loss of license or probation.

We must all accept responsibility when we fail those members of the physician community by allowing them to continue to practice when they are compromised by substances which in many instances are addicting, whether physiologically or psychologically.

Let's not allow the present situation to continue wherein the majority of physicians referred to this Committee for assistance have already been under investigation by the Board of Medical Examiners or are under suspension or probation. We must give very careful consideration to how we can continue to allow a physician to practice if we suspect that he or she is compromised by the use of some type of chemical. Would we condone his or her treatment of ourselves or our families with this knowledge?

I want to express my sincere thanks and the appreciation of the entire membership to Dr. Grimball and his committee for their compassionate attention to one of the most difficult problems with which our profession is confronted.

We *are* our brother's keeper and must remain so.

Until next month,

A handwritten signature in dark ink, appearing to read "Ken", followed by a long, sweeping horizontal line.

KENNETH N. OWENS, M.D.
President



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The views expressed in this publication are those of the writers and do not necessarily reflect the opinions of the South Carolina Medical Association.

INFORMATION FOR AUTHORS

Authors should refer to the detailed instructions in the January issue. Manuscripts and other correspondence should be addressed: The Editor, JOURNAL OF THE SOUTH CAROLINA MEDICAL ASSOCIATION, Post Office Box 11188, Columbia, S. C. 29211.

All manuscripts should be accompanied by a transmittal letter with the following paragraph: "This original work has not been submitted or published elsewhere, in entirety or in part. I (we) hereby transfer, assign, or otherwise convey all copyright ownership to the South Carolina Medical Association in the event that this work is published by the SCMA."

We request that manuscripts be concise (no longer than 8 typewritten pages, double-spaced), with no more than ten references. These should be cited in the text in superscript, e.g., "Bottsford, et al.³", and should conform to the following style: "3. Bottsford JE, Bearden RC, Bottsford JG: A ten year community hospital experience with abdominal aorta aneurysms. *J S C Med Assoc* 79: 57-62, 1983." Ordinarily, publication of four small illustrations or tables or the equivalent will be paid for by *The Journal*. Manuscripts should be submitted in duplicate. Reprints will be made available by the publisher.

From the State House: LEGISLATIVE UPDATE



March 1985

The Honorable David O. Hawkins, Chairman of the House Medical Affairs Committee, was the keynote speaker at the SCMA's First Annual Leadership Conference on February 27. Mr. Hawkins outlined legislative issues of concern to the SCMA regarding Medical Malpractice and Tort Reform. Mr. Hawkins stated, "I understand that when the reform package was presented to the Trial Lawyers Association, progress on that issue slowed down considerably. I hope that you are successful in working out most of the areas of disagreement, and also want to encourage you to work through the legislative process. You may find the General Assembly to be a bit more receptive to your concerns than the Trial Lawyers were." Concerning the SCMA's lobbying strength, Mr. Hawkins offered, "Your association has staff who are paid to keep up with what goes on at the Statehouse. With the large number of bills and committees considering those bills, such staff are invaluable. I must admit, however, when it comes to testifying or writing to us about the impact of legislation, legislators take special note if a physician speaks directly on a matter, particularly if that physician is also a constituent. Sometimes it is hard for a legislator to know the personal impact of a bill and it helps to have someone who is out in the community to discuss the bill with, to ask questions, and to answer questions. I know that your appointment schedules are hectic and that some patients claim they do not get enough of your time, but if some of you can take the time to contact legislators in your home county and explain how you feel about an issue and why, it will benefit not only you and the legislators, but hopefully society as a whole."

INDIGENT CARE BILL UNCERTAIN

As the legislature nears the midpoint of the 1985 session, the fate of the Indigent Care Bill is uncertain. Several variables, including the ramifications of President Reagan's proposed cap on Medicaid-Medicare Program, have yet to be measured. The National Governor's Conference voted to oppose the proposed cap as did the Southern Governor's conference. A contingent of South Carolina legislators, including David Hawkins, Chairman of the House 3M Committee; Robert Helmly, chief sponsor of H.2118; and others met with the members of the South Carolina Federal Delegation to express concern over the Medicaid cap. The bill has been incorporated into the 1985 Appropriations Bill. Further information will be forthcoming.

LIVING WILL BILL CONSIDERED IN STATE SENATE

On February 20, 1985, Kenneth N. Owens, MD, President of SCMA, testified in support of H.2041 before a Senate Medical Affairs Subcommittee. H.2041 has been favorably considered by the House and appears to be in good shape on the Senate side.

Labeled by some as the "death with dignity" bill, the legislation will provide the option for an adult to declare the desire for life sustaining devices, or procedures, to be withheld if the party concerned has an incurable condition that will result in death within a short period of time. The legislation contains numerous safeguards designed to protect the patients and physicians involved.

In order for a "living will" to be received as valid, two witnesses, neither of whom may be related to the patient or involved in his estate, must be present at the signing.

Prior to withdrawing life-sustaining devices, two physicians are required to certify death as imminent and that the use of life sustaining devices would only serve to prolong the process. The will could be broken by the patient verbally or by destroying the document.

MANDATED HEALTH BENEFITS BEFORE HOUSE AND SENATE

The erroneously dubbed "insurance equality" or "freedom of choice" bills continue to be the focus of the lobbying efforts of the SCMA, SCHA, and several business coalitions in the state. The legislation proposes that ancillary health care providers be covered under the same schedule as primary care physicians. The effect of the legislation is to mandate coverage of services provided by chiropractors, psychologists, and optometrists.

Other states with identical legislation have experienced tremendous increases in the cost of health care due to the mandated benefits. One explanation for the rise in cost appears to be the increased office visits paid by the patient to non-MD professionals. All states experienced excessive increases in the area of chiropractic care, coupled with an increase in the "usual and customary" cost of such visits. Presently, the option to include coverage for chiropractic, optometric, and psychological treatment is available to anyone who desires the benefits be included in their policies.

The SCMA feels strongly that mandated insurance coverage is a perversion of the free enterprise system and continues to devote the necessary energy to oppose such legislation.

Your efforts to ensure the defeat of this legislation would be most appreciated. Should you have any questions regarding this issue, please contact Susie Nickles, 798-6207.

LEGISLATIVE UPDATE TO BE MAILED SEPARATELY

Because we feel that including this monthly "Legislative Update" in The Journal places some time constraints on getting information to members as quickly as possible, this will be the last "Update" to appear in these pages. In the future, all members should expect and watch for "Legislative Update" mailings as important events occur in the General Assembly. We appreciate the generosity of the Editorial Board for having allowed us the use of The Journal as a forum for the update in the past several years.



DISTAL DIGITAL REPLANTATION*

HUGH J. HAGAN, M.D.**

EDWARD L. HAY, M.D.

GERALD J. SHEALY, M.D.

In the past 15 years, replantation of amputated digits has become an accepted procedure. We recently reported our experience with replantation of amputations in the upper extremity and outlined the indications for this procedure.¹ Advances in technique and experience now allow an anastomosis of vessels less than 1mm in diameter and thus more distal replantations are possible. This paper outlines several illustrative cases and our experience with replantation of digits amputated at or distal to the distal interphalangeal joint.

CASE REPORT NO. 1

A 34-year-old right-handed man suffered complete amputation of his left thumb at the base of the distal phalanx on a power saw. He was transported from an outlying area with the amputated thumb wrapped in saline-moistened gauze and placed in a sterile container on a bed of ice. The thumb was replanted under regional block in four hours and 40 minutes. Hospitalization time was six days. He had returned to full duty as a manager in 40 days with protective thumb sensibility showing improvement at that time. He was very pleased with his result (Fig. 1).

CASE REPORT NO. 2

A 31-year-old right-handed man suffered complete amputation of right middle finger through

the distal interphalangeal joint in a heavy machine at work. The finger was replanted in five hours under general anesthesia. Total hospital time was eleven days. The patient had returned to duty by 54 days and at two year follow-up had two point discrimination of 10mm and was very satisfied with his result (Fig. 2).

CASE REPORT NO. 3

A three-year-old right-handed girl suffered complete amputation of her right index finger at the level of the distal interphalangeal joint with an ax. Replantation was performed under general anesthesia in three hours and 50 minutes. Hospital time was seven days and at three years follow-up the child continued right-hand dominant with a good functional and cosmetic result.

DISCUSSION

Absolute indications and contra-indications for replantation of an amputated part are reviewed in Table I.² The question of whether the result of distal and single digit replantation justifies a major surgical procedure and a week in the hospital has been raised in the past.^{3, 4} A review of the recent

Table I

Absolute Indications

1. Arm, forearm, or hand
2. Midpalm
3. Thumb
4. Multiple digits
5. Any part in a child

Contraindications

1. Severe crushing
2. Warm ischemia greater than six hours
3. Elderly or chronically ill patient

* From the Department of Orthopaedic Surgery, Medical University of South Carolina (Drs. Hagan, Hay, and Shealy), and Hand Surgery Associates, 30 Bee Street, Charleston, S. C. 29403 (Drs. Hay and Shealy).

** Address correspondence to Dr. Hagan at the Department of Orthopaedic Surgery, Medical University of South Carolina, 171 Ashley Avenue, Charleston, S. C. 29425.

DIGITAL REPLANTATION



FIGURE 1. A. Complete amputation of thumb. B and C. Post-operative appearance.



FIGURE 2. A. Amputation of the right middle finger. B and C. Post-operative appearance.

literature^{5, 6, 7} shows a high (75 to 95%) success rate of single and more distal replantations with good patient acceptance. A large prospective study⁸ comparing the results of amputation revision and replantation showed equal grip strength and overall hand function in patients with distal digital amputations, but a much more rapid return to full duty for patients with replanted digits. A review of patients undergoing distal digital replantation in Charleston, South Carolina (19 replants) showed an overall success rate of 78 percent with average operating time of three hours six minutes and average hospitalization time of seven days. Two of the four unsuccessful replantations were of digits with more severe crushing or avulsing

injuries. The patients with successful replantation returned to work at an average of 63 days post injury. Our experience has shown that patients with distal replantation of a finger or thumb do better than their counterparts with amputation in several ways. Length of the digit is maintained with more acceptable cosmetic appearance. Maintenance of the insertion of the flexor digitorum profundus provides greater strength in finger flexion and grip. Loss of distal interphalangeal joint motion, a common result from either ankylosis or intentional joint fusion provides a stable distal segment and little functional problem. Cold intolerance has not been a major functional problem though several patients have reported it.

SUMMARY

Replantation of single distally amputated fingers and thumbs should be considered in those patients in whom a specific contraindication to surgery is not present. The patient should be transported to an institution with facilities and personnel for replantation available. The amputated part should be wrapped in saline-moistened gauze, placed in a sterile container and transported on a bed of ice. Successful replantation of distal digital amputations is generally associated with a more rapid return to full duty at work and a more acceptable cosmetic and functional result than amputation alone. □

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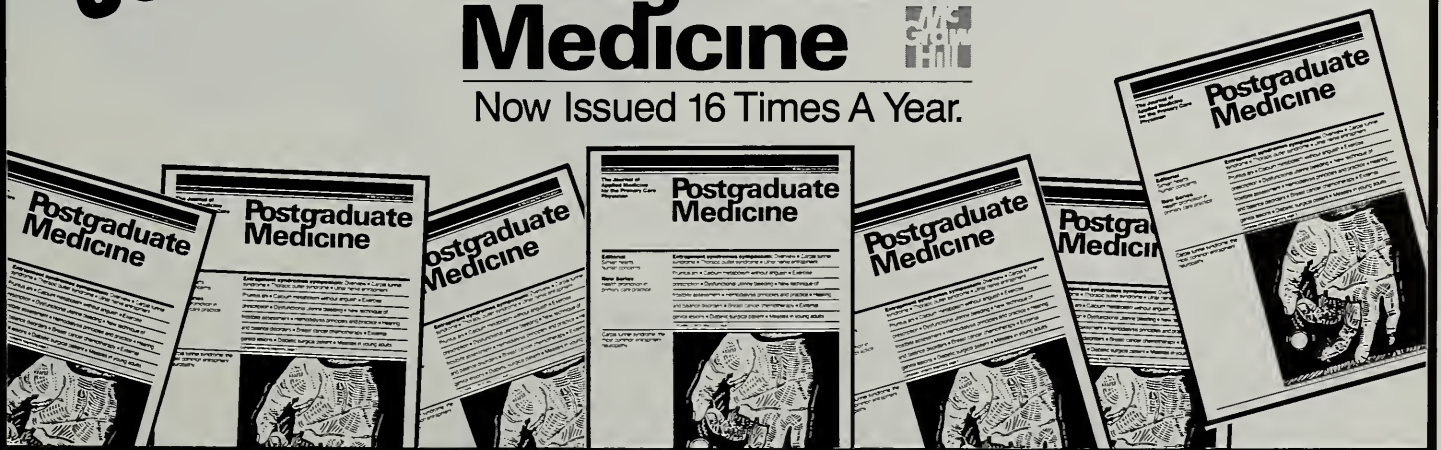
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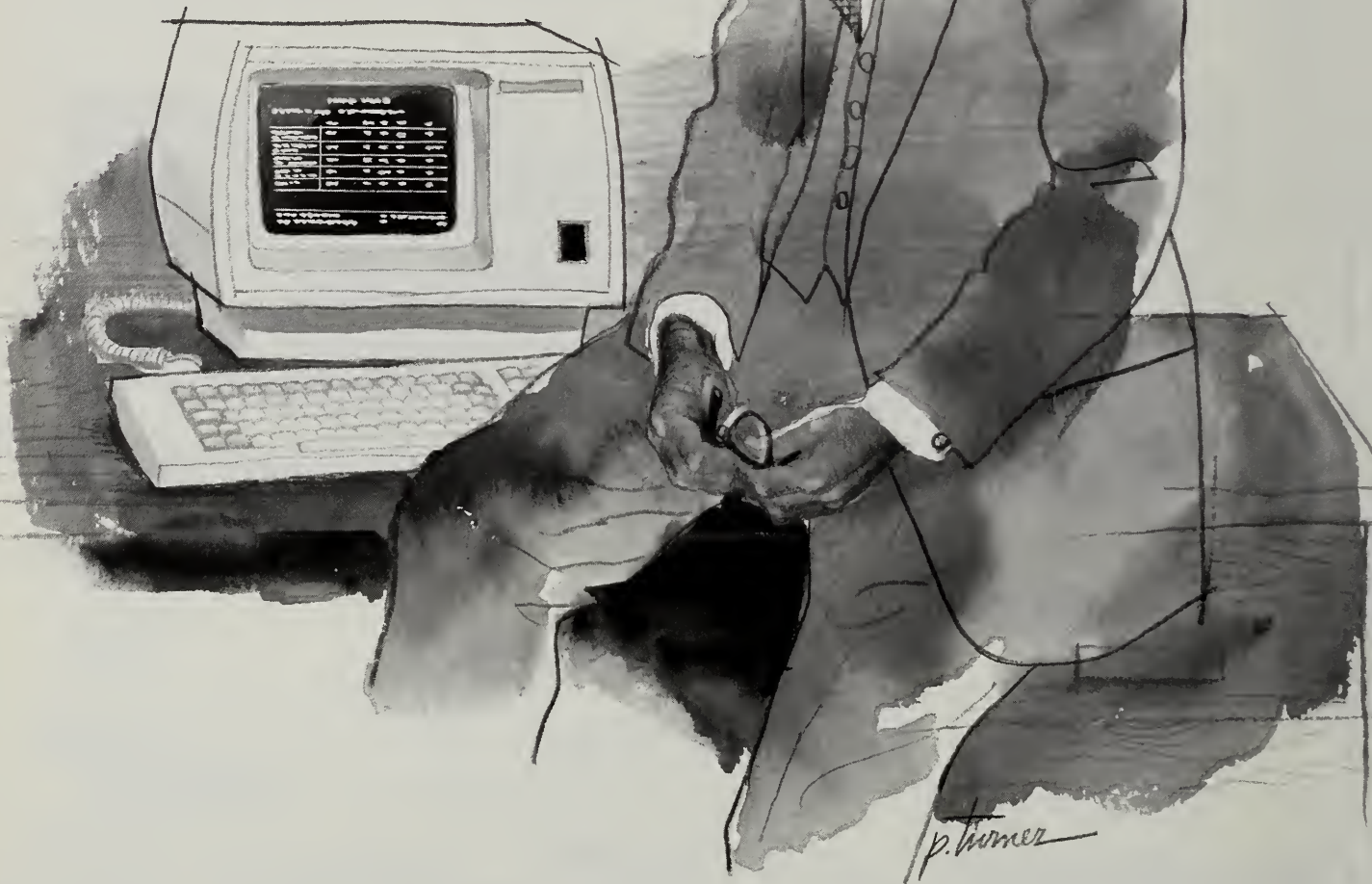
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NON-IMMUNE HYDROPS FETALIS: A REVIEW OF FIVE CASES*

SHARADA PAI, M.D.**

TOM L. AUSTIN, M.D.

With the advent of preventive strategies for RH isoimmunization, there has been a relative increase in the number of cases of hydrops fetalis with a non-immune etiology. Hydrops fetalis is a condition associated with generalized edema of soft tissues and serous effusions in the peritoneal, pleural and pericardial spaces. Numerous causes of non-immune hydrops fetalis (NIHF) have been identified in reviews and case reports¹⁻⁵ since Potter first described it in 1943.⁶ The mortality has varied from 50 to 95 percent.² Five cases of NIHF were encountered over a two-year period in the Neonatal Intensive Care Unit at Richland Memorial Hospital. Three babies survived the neonatal period, resulting in a neonatal mortality of 40 percent. There has been only one survivor over one year of age.

CASE REPORTS

The medical records of five patients with NIHF were reviewed. Table I describes antenatal and intrapartum factors associated with NIHF in these cases. All five infants were premature and gestational ages ranged from 28 to 34 weeks. Mean birthweight was 2,191 grams and three of the infants had weights in excess of that predicted for their gestational ages, reflecting the generalized body edema. All mothers were Rh positive and their ages ranged from 20 to 31 years. Prenatal complications included polyhydramnios in three mothers, pre-eclampsia in one and recurrent urinary tract infections in one mother. Prenatal diagnosis of hydrops was made in four mothers by ultrasonography. Delivery was by Cesarean section in three mothers and by vaginal route in two. Apgar scores were uniformly poor, with the highest score at one minute being 3 and at five minutes 5. All infants required complex resuscitation at

delivery and were admitted to the neonatal intensive care unit. Three infants were outborn and two inborn. The placenta was grossly normal in one case, there was normal histopathology in one case, an abnormal placenta was found in two cases and it was not examined in one case.

Table II shows the clinical and laboratory findings on admission. All infants had generalized edema, three had hydrothoraces and four had ascites. None of the infants had splenomegaly and only two had definite hepatomegaly. Weight loss ranged from 5.6 percent to 28 percent of original body weight. Central hematocrit on admission ranged from 25 percent to 56 percent. None of the infants had a positive direct Coombs test. Admission blood pressures ranged from 33-87 mmHg systolic to 18-52 mmHg diastolic. Total protein ranged from 2.5-4.0 gms/dl.

Table III delineates therapy, outcome and the probable etiology for NIHF in each case. Transfusion of whole blood or packed cells was used in all five infants. One infant received an exchange transfusion for high indirect hyperbilirubinemia. Platelet transfusion was given to one infant. Thoracentesis was performed in the three infants with pleural effusions and paracentesis was done in three of four infants with ascites. Continuous central blood pressure (BP) monitoring was done in all cases through umbilical arterial lines. Central venous lines could not be placed in four of the five infants. On echocardiography, all five cases showed increased pulmonary vascular resistance, two were consistent with decreased left ventricular contractility and one had abnormal pulmonary valve closure. All infants required assisted ventilation with peak inspiratory pressure (PIP) ranging from 25-41 cms of H₂O, positive end expiratory pressure (PEEP) from 4-6 cms of H₂O, inspired oxygen (FiO₂) from 0.78-1.0 and intermittent mandatory ventilation (IMV) rate from 40-51 breaths per minute. Measurement of initial arterial blood gases showed a pH range from 6.94-7.44, PaCO₂ from 30-77 mmHg and PaO₂

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HYDROPS FETALIS

TABLE I
ANTENATAL AND INTRAPARTUM FACTORS
IN 5 CASES OF NIHF

	Case 1	Case 2	Case 3	Case 4	Case 5	Mean \bar{X}
Birthweight	2,820 gms	2,940 gms	1,600 gms	1,720 gms	1,875 gms	2,191 gms
Gestational age	34 wks LGA	34 wks LGA	32 wks AGA	28 wks LGA	32 wks AGA	32 wks
Maternal age	22 yrs	29 yrs	20 yrs	31 yrs	27 yrs	25.8 yrs
Blood type	A pos.	O pos.	O pos.	O pos.	O pos.	-
Prenatal Complications	Pre-eclampsia	Polyhydramnios	Recurrent UTI, Premature labor	Multiple gestation, Spotting, Polyhydramnios	Polyhydramnios	-
Prenatal Diagnosis	Fetal hydrothorax by u/s*	Hydrops by u/s*- amniocentesis with dye injection showing patent G.I. tract	None	Serial u/s*, Fetal ascites in one twin	Single u/s*	-
Delivery	Primary Elective C- Section	Vaginal	Emergency C-Section	Emergency C-Section	Vaginal	-
Placental Pathology	Normal	Not examined	Abruptio	Velamentous insertion of cord and hydropic placenta	Normal	-
Apgar 1/5 Score	3/5	1/1	1/3	1/2	2/4	1.6/3
Delivery Facility	Inborn	Outborn	Outborn	Inborn	Outborn	-

*u/s - Ultrasound

TABLE II
ADMISSION CLINICAL AND LABORATORY DATA
IN 5 CASES OF NIHF

	Case 1	Case 2	Case 3	Case 4	Case 5
Edema	Generalized	Generalized	Generalized	Generalized	Generalized
Pleural Effusion	+	+	-	-	+
Ascites	+	+	+	+	-
Hepatomegaly	-	+	Abdominal Mass	+	-
Splenomegaly	-	-	Abdominal Mass	-	-
Lowest wt.	Rapid demise	2,160	1,150	1,310	1,770
Weight Loss %	Rapid demise	26%	28%	23.8%	5.6%
Admission Hct. (central)	35%	41.8%	26%	56%	55%
Admission Platelet Ct.	Estimate low on CBC	Estimate normal	182,000	49,000	51,900
Blood Type	O pos. Coombs neg.	O neg. Coombs neg.	A pos. Coombs neg.	A pos. Coombs neg.	O pos. Coombs neg.
Admission B/P	87/52	40/22	51/32	33/18	46/21
Total Protein	2.5	2.9	4.0	3.7	3.0

+ = yes
- = no

HYDROPS FETALIS

TABLE III
THERAPY, OUTCOME AND ETIOLOGY
IN 5 CASES OF NIHF

	Case 1	Case 2	Case 3	Case 4	Case 5
Transfusion					
a) Exchange	-	-	-	+	-
b) Whole Blood	+	-	+	+	+
c) Packed Cells	-	+	+	+	+
d) Platelets	-	-	-	+	-
Thoracentesis	+	+	-	-	+
Paracentesis	+	+	-	+	-
Central B.P. Monitoring through U.A.C.	+	+	+	+	+
Digitalis	-	-	-	-	-
Diuretics	+	+	+	+	+
Outcome	Died at 20 hrs	Died at 5 mos. of age	Alive	Died at 2 mos.	Died at 14 days
Autopsy	yes	yes	Alive	yes	yes
Cause	None identified	Trisomy 21 syndrome	Prenatal intestinal volvulus, ileal atresia and cystic degeneration, Cystic Fibrosis	Intra-hepatic biliary atresia	Choledochocolonic fibrous band with obstruction at the transverse colon

from 55-177 mmHg. One infant expired within 24 hours after birth, one expired at two weeks and three survived the neonatal period. Post-neonatal mortality claimed two of the surviving infants. The sole surviving infant has been re-admitted to the hospital several times with recurrent pneumonia.

The etiologies were diverse. Case 1 did not have an identified cause. Case 2 had Trisomy 21 syndrome. Case 3 had cystic fibrosis (confirmed by multiple sweat chloride levels and stool trypsin analysis), prenatal volvulus with ileal atresia and cystic degeneration of the involved bowel. Case 4 was diagnosed as having intrahepatic biliary atresia and Case 5 was found to have a choledochocolonic fibrous band with obstruction at the transverse colon. All four babies who died had autopsies. To our knowledge, neither intrahepatic biliary atresia nor choledochocolonic band has been reported in association with hydrops fetalis.

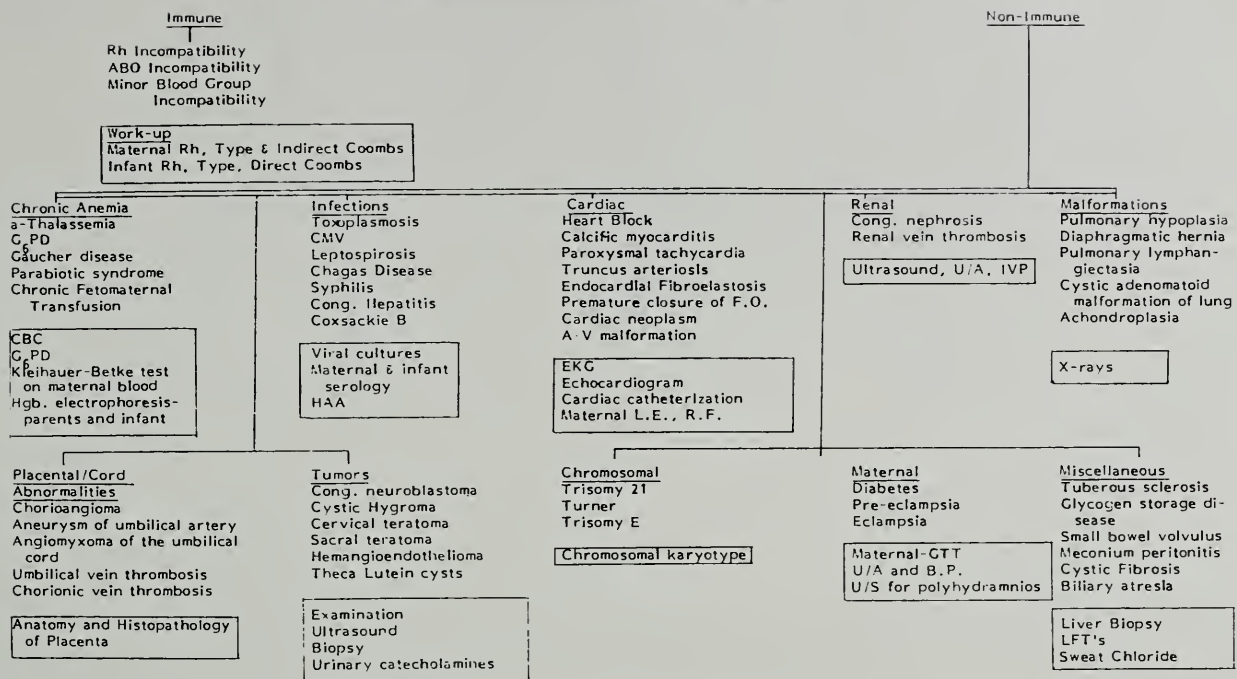
DISCUSSION

The pathophysiology of hydrops fetalis is unclear and several mechanisms have been postulated,⁷ of which the three major categories are hemodynamic disturbances, decreased plasma oncotic pressure and increased capillary permeability. A majority of the identified etiologies of NIHF seem to be related to one or a combination of these factors. The presence of fetal edema

is easily diagnosed prenatally by ultrasonography, and should be suspected in gravidas with hydramnios or when the uterine size is greater than expected for gestation. Appropriate prenatal and perinatal management, including amniocentesis, fetal heart rate monitoring and Kleihauer-Betke test on mother's blood should be initiated. The latter should preferably be performed prior to amniocentesis or delivery to decrease the possibility of releasing fetal cells into maternal circulation.³ The neonatal team should be prepared for a complex resuscitation, and maternal transport to a tertiary level hospital is strongly recommended.¹ Babies with NIHF frequently need aggressive cardiorespiratory therapy, including mechanical ventilation and removal of pleural and ascitic fluid. When an immune etiology is ruled out with a blood type, Rh type and Coombs panel, an immediate search should be initiated for a non-immune cause. Laboratory tests which may be of value are listed in Table IV. Concurrent management should address the immediate problems of oxygenation and ventilation which may require high peak inspiratory pressure (PIP), ventilatory rates and positive end expiratory pressure (PEEP). Inadequate perfusion and reduced blood volume should be treated with whole blood or partially packed cells. Central arterial BP and central venous pressure (CVP) monitoring could be invaluable in the treatment. Early in the course

HYDROPS FETALIS

TABLE IV
DIFFERENTIAL DIAGNOSIS OF HYDROPS FETALIS



or without arterial hypotension, which is at least partially attributed to peripheral vasoconstriction secondary to birth asphyxia.⁸ The low cardiac output usually improves with adequate oxygenation and correction of metabolic acidosis. Later, an increase in CVP could indicate myocardial failure or hypervolemia. The use of colloid in this situation is controversial.⁹ Opponents of colloid therapy argue that albumin increases pulmonary microvascular pressure and this negates the effect of increase in the intravascular osmotic pressure. Also, the infused protein leaks into the pulmonary interstitium and could potentiate the pulmonary edema. Pulmonary edema can be managed with continuous positive airway pressure and diuretic therapy. Because of this high incidence of perinatal asphyxia and other related problems, disseminated intravascular coagulation can occur. This needs prompt management with either component therapy using fresh frozen plasma and vitamin K or exchange transfusion using fresh whole blood. Severe symptomatic thrombocytopenia may need platelet transfusion therapy. Echocardiography can aid in the diagnosis of myocardial dysfunction and associated persistent fetal circulation. If echocardiography confirms the decreased myocardial contractility, cardiotonic agents such as Dopamine¹⁰ may be indicated.

Even though the mortality in most reviews is high, the fetal outcome could change with early

prenatal diagnosis using ultrasonography. Optimal support should be provided for the fetus and neonate with hydrops, and decision regarding viability postponed until the underlying etiology is determined. If the diagnosis of NIHF is made prior to delivery, parents should be informed of the risk to the fetus and supportive counseling instituted. Specific genetic counseling may be indicated in those instances where an etiology is established. Autopsy should be strongly recommended to parents of infants who expire, especially those cases which have been labeled "idiopathic," after extensive clinical lab tests failed to establish a cause for NIHF.

SUMMARY

Five neonates with non-immune hydrops fetalis (NIHF) were seen at Richland Memorial Hospital over a two-year period. The etiology of the NIHF included one case each of cystic fibrosis, intra-hepatic biliary atresia, choledochocolonic band and Trisomy 21 syndrome. In one infant the etiology could not be determined. The mortality and morbidity associated with NIHF is high. However, earlier diagnosis using prenatal ultrasound and aggressive resuscitation could change the outcome. □

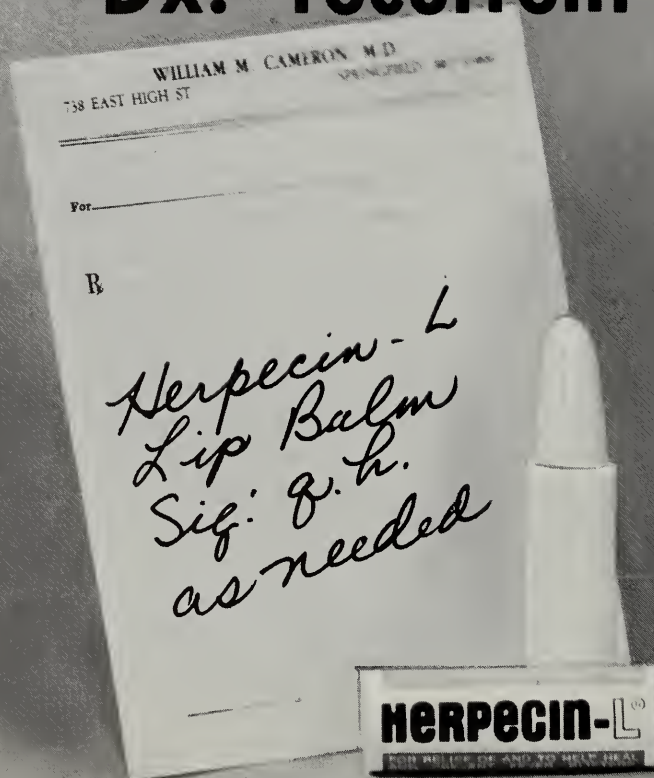
ACKNOWLEDGEMENT

We gratefully acknowledge Leslie W. Shelton, Jr., M.D. for interpretation of echocardiograms and Sue Loadholt for preparation of the manuscript.

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SCMA

NEWSLETTER

March, 1985

SCMA LEADERSHIP CONFERENCE TO BECOME ANNUAL EVENT

Participants responded so enthusiastically to the first SCMA Leadership Conference that this educational opportunity will now become an annual event for SCMA and county medical society officers, as well as Auxilians, statewide.

Approximately 80 physicians and Auxilians attended the Conference in Columbia on February 27, at which *David O. Hawkins*, Representative from District 38 in Spartanburg County and Chairman of the House Medical, Military, Public and Municipal Affairs was the keynote speaker. Representative Hawkins discussed legislative issues in medical and health-related areas now before the South Carolina General Assembly. He stressed the importance of physician input in the legislative process, and praised the physicians for the SCMA voluntary "Doctor of the Day" program.

Earlier, participants were briefed on SCMA's position with regard to numerous Bills under consideration by the General Assembly, as well as the SCAPELL program and SOCPAC.

Bruce D. Blehart, Assistant Director of the Department of Federal Legislation of the AMA, presented legislative issues and AMA involvement on a national level. *John W. Simmons, M. D.*, Spartanburg, described the private review process of the S. C. Medical Care Foundation which is being promoted, along with wellness programs, to business and industry as major efforts to curb the increasing costs of health care.

Science Writer for the American College of Pathologists, *Barbara Chapman*, and *Robert Hitt*, Managing Editor of the *Columbia Record*, discussed physician/media relationships and means to improve communications between the media and the medical profession.

Presidents and Presidents-Elect (or their designees) should plan to attend next year's session for a valuable learning experience. To facilitate planning and scheduling, the date will be announced as early as possible.

SCMA ANNUAL MEETING

REGISTRATION FORM - SEE PAGE 3

AMA FEE FREEZE ACTIONS

The AMA Board of Trustees, meeting last month in Chicago, took several key actions on Medicare reimbursement and the physician fee freeze. It also renewed its appeal for all physicians to continue giving special consideration to patients in financial need.

A year ago last month, the Board issued a nationwide call for all physicians to voluntarily freeze their fees for all patients for one year. The SCMA responded by supporting this action at its 1984 meeting of the House of Delegates.

The Board issued the following statement regarding this voluntary freeze on physicians' fees:

"In February, 1984, the AMA asked all physicians in the U. S. to freeze their fees voluntarily. Survey data show that nearly 80 percent of them complied with that request and in the process saved their patients approximately \$1.5 billion. The AMA Officers and Board of Trustees commend America's physicians for this response.

"For the future, the Board and Officers urge that physicians continue to consider each patient's financial needs when setting their charges -- especially for the unemployed, the uninsured and those on Medicare and to accept reduced fees or not at all when warranted.

"The AMA Board and Officers recognize that some physicians will need to adjust their fees because of increasing costs of practice, but we hope as many physicians as are able will maintain current levels or make only those changes as are needed to meet inflation in their overhead."

In other actions, the Board voted to oppose a freeze on hospital reimbursement in the absence of a showing that access to and quality of care would not be adversely affected and cost-shifting would not be increased. The Board also voted opposition to the continuation of the freeze on physician fees and the freeze on reimbursement for clinical lab services. The Board supported an appropriate increase for Medicare physician and hospital reimbursement, unless Congress legislates an across-the-board freeze of domestic and defense spending, and also supported earlier AMA recommendations to reform the Medicare Trust Fund and Medicare program to remove some of the fiscal pressures on both Part A and Part B.

PROFESSIONAL LIABILITY ACTION PLAN

Another action of the AMA Board of Trustees at its February meeting was to approve the AMA Special Task Force on Professional Liability and Insurance Action Plan.

The plan is divided into four principle parts and provides recommendations for Education and Community Action; for legislation to achieve state and federal tort reform and judicial reform; for defense coordination; and for risk control and quality review.

The Action Plan report will be bound into the March 22 issue of *American Medical News*, and copies will be available soon to the SCMA. The report will be referred to the SCMA Committee on Professional Liability.



SCMA 137th Annual Meeting and Scientific Assembly April 24 - 28, 1985

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APRIL IS HEALTH PROMOTION MONTH

Governor Richard W. Riley has proclaimed April as Health Promotion Month to focus attention on the need to alter lifestyle practices in an effort to improve the health status of South Carolinians.

The Governor's office will be involved in health promotion through recognition of exemplary health promotion programs for the elderly, schools and worksites. Other health promotion activities scheduled for April are Women's Running Week, Health Fairs in South Carolina, World Health Day, State Employee Wellness Week and the Institute on Employee Assistance Programs and Health Promotion Programs at the Worksite.

Information about risk factors and health promotion activities may be obtained from *Ms. Dorothy Maysey, Office of Health Education, South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia 29201 (758-5555).*

AMA PHYSICIANS' PROFESSIONAL ACTIVITIES CENSUS

AMA's quadrennial Physicians' Professional Activities Census will be conducted throughout 1985 beginning this month.

Easy-to-complete PPA Census questionnaires will be mailed to every physician in the United States. By completing the forms physicians are assured that they will be correctly identified by their practice specialty and current professional activities in AMA records and the American Medical Directory. Additionally, AMA records classifications serve as the basis for distribution of scientific and educational information from the AMA and for determinations that are made in arranging complimentary mailings of AMA journals and mailings of materials from pharmaceutical companies.

Physicians are encouraged to complete and return the PPA Census forms. Any physician not receiving a form by April 30 may call the AMA (312/645-5136) to obtain one.

COST CONTAINMENT CHECKLIST AVAILABLE NOW

"Cost Containment Checklist," a nine-page publication released by the AMA, describes many practical ways in which physicians can reduce costs. The booklet updates an AMA checklist published in 1978. Individual copies are available AT NO CHARGE from the *Department of Health Care Financing and Organization, AMA Headquarters, 535 N. Dearborn Street, Chicago 60610.*

CAPSULES....

...*SCMA Delegate to the AMA C. Tucker Weston, M. D.,* will serve as Chairman of Reference Committee B (Legislation) at the AMA Annual Meeting, June 16-20, in Chicago....

....*Charles H. Banov, M. D., of Charleston,* has been installed as President of the American College of Allergists. Dr. Banov is Associate Professor of Medicine and Bacteriology/Immunology at MUSC and also has a private practice in clinical allergy. He is immediate Past President of the S. C. Society of Allergy and Immunology and serves on the Board of Directors of the Joint Council on Allergy and Immunology....

FIVE UNUSUAL OTORHINOLARYNGEAL CASES

R. W. HANCKEL, M.D.*
J. STOVALL KING, M.D.

The senior author has encountered five unusual otorhinolaryngeal cases during his first year at the McLeod Regional Medical Center.

CASE REPORTS

Case 1. A 75-year-old male was referred to the neurological service because of a left parietal mass discovered on CT scan. Intermittent purulent drainage had been present from the left ear since World War II when he worked as a chipper in a naval base. A chip had fallen into his ear and perforated the drum. About two weeks before admission to the neighboring hospital, the patient had developed a left facial paralysis.

Dr. Meier performed a left parietal craniotomy and drainage of a brain abscess. The patient had an uneventful recovery from this procedure.

The patient was seen in consultation because of persisting foul-smelling, purulent discharge from the left ear, left facial paralysis, and x-ray evidence of chronic left mastoiditis. On examination, there was a large amount of foul-smelling watery discharge in the left canal and middle ear. There was a perforation in Shrapnell's membrane in the left drum.

On February 23, 1983, a left modified radical mastoidectomy was performed. At operation, a large cholesteatoma was found which extended from just under the mastoid cortex to the mastoid antrum. This was removed in toto and sent as a surgical specimen to the pathology laboratory. The tegmen was partially destroyed and the underlying dura was somewhat whitish in color. The remainder of the tegmen was removed until normal dura was observed. There was erosion of the semicircular canal. In the ossicular chain, only the handle of the malleus and the footplate of the stapes with portions of the crura remained. Since there was almost an intact drum present and since a portion of the ossicular chain remained, it was decided to do a modified radical mastoidectomy. The bony posterior canal wall and facial bridge

were removed and the middle ear explored for remnants of cholesteatoma, but none was found. The facial nerve appeared intact. The middle ear was explored under microscopic guidance.

The patient made an uneventful recovery and obtained a dry ear and healed tympanic membrane. He decided not to have an elective tympanoplasty in an attempt to improve his hearing. The facial paralysis cleared spontaneously.

COMMENT: The reason for reporting this case is that the incidence of brain abscesses of otitic origin has dropped from 56 percent in 1931 as reported by Evans to 12 percent in 1969 as reported by Beckhuis and Taylor in 1981 because of the advent of antibiotics.¹

Case 2. A 15-year-old male was admitted to the neurology service by Dr. Brazis for the acute onset of major motor seizures. These had started several hours before admission. His seizures were so persistent that he required a general anesthetic before a CT scan of the head could be done. This revealed a pansinusitis. The main feature of a physical examination was a profuse purulent nasal and postnasal discharge.

The patient had previous history of allergic and infectious rhinosinusitis, chronic adenotonsillitis and bilateral serous otitis. In 1973, at five years of age, he had an adenotonsillectomy and bilateral tympanosotomies with insertion of tubes by Dr. C. H. Truluck, Jr. Shortly after this, he was referred to Dr. Peter Williams for the treatment of allergy.

On August 15, 1983, an operative procedure consisting of a bilateral Caldwell Luc with trans-antral ethmoidectomies was done. Much pus, granulation tissue, and thickened mucosa were found in both the antra and the ethmoids.

He made an uneventful recovery from his sinus surgery and was alert and cooperative. However, a repeat CT scan on August 24, 1983 showed a left frontal lobe abscess not evident in any of his previous computerized tomographic scans. Dr. Gerald F. Meier saw the patient in consultation and on September 2, 1983, performed a left frontal craniotomy. At operation, an extra-dural abscess was found and drained.

* Address correspondence to Dr. Hanckel at 506 East Cheves St., Suite 101, Florence, S. C. 29501.

Again, the patient made an uneventful recovery and was discharged on September 9, 1983. He has remained free of recurrent disease.

In retrospect, this patient had a chronic allergic and purulent pansinusitis since childhood which had begun penetration of the posterior wall of his left frontal sinus at the time of his hospital admission, producing a localized meningitis. This accounted for seizures on admission. During his hospital stay, he developed a localized extra-dural abscess.

COMMENT: Beckhius and Taylor in 1981 reported a 50 percent mortality from brain abscesses of rhinogenic origin, a figure almost twice that of brain abscess of otitic origin. Of interest also, is the decrease in brain abscesses of rhinogenic origin since the advent of antibiotics in the latter 1930s.²

Cases 3 and 4. The next two cases represent spontaneous (non-traumatic) cerebrospinal rhinorrhea. Inasmuch as the senior author has been in both the private and academic practice of otorhinolaryngology since 1940, and as these are the only cases of this kind that he has encountered, it seemed appropriate to report them.

The first of these is that of a 38-year-old female referred by Dr. G. Jones of Manning, South Carolina.

She gave a history of having a clear watery discharge from the right nostril since March of 1983. There was no history of injury, no nasal obstruction, and no known allergies.

A sinus x-ray, brought in by the patient was non-revealing except for a partial cleft palate.

Examination of the nose was normal, except for a persistent clear watery discharge from the right nostril, more evident when she leaned forward with the back of her head parallel to the floor.

Examination of the remainder of her ear, nose, and throat was within normal limits. A 5ml. specimen of the clear fluid was collected and the specimen was sent to the laboratory at MRMC. Examination revealed that this contained 85 milligrams percent of sugar, confirming our suspicion that it was cerebrospinal fluid.

The patient was referred to a local neurosurgeon, J. Stovall King. Extensive examination by our radiologists using metrizamide and CT scans revealed that the site of the leak was the right cribriform plate. A craniotomy was done and the leak in the right cribriform plate was repaired using methyl methacrylate bioglue. She made an uneventful recovery. She was readmitted to the

hospital for the placement of lumboperitoneal shunt to prevent recurrence of CSF rhinorrhea.

The second of these cases of spontaneous (non-traumatic) cerebrospinal rhinorrhea was that of a 52-year-old woman referred to Dr. J. Stovall King. There was no history of trauma, only the sudden appearance of a clear fluid from the left nostril which had persisted for the past month. It was most evident when she held her head forward.

However, a careful inspection of the left nostril after the application of Adrenalin 1:1000 and two percent Pontocaine on a pledget of cotton failed to reveal the exact source of the leak. The leak was demonstrated by metrizamide CT scan.

A left craniotomy was carried out and a dehiscence was found in the left cribriform plate. This was repaired using muscle, freeze dried dura and methyl methacrylate glue.

The patient made an uneventful recovery and has had no recurrence of her leak of spinal fluid. This patient also had a lumboperitoneal shunt to prevent recurrence.

COMMENT: These cases are rare. Since 1970, 10 patients have been treated for cerebrospinal rhinorrhea at the UCLA Medical Center. Of these, five were non-traumatic and four of the five were from the cribriform plate area, the fifth being from the sphenoidal sinus.³ Five such cases have been treated at McLeod Regional Medical Center over the past five years. Three of these have been spontaneous and two cases post-traumatic.

Case 5. A 68-year-old woman was referred by Dr. A. Q. Manghi of Dillon, South Carolina because of some difficulty in breathing of three week's duration.

A mirror examination of the larynx revealed a subglottic tumor partially obstructing the trachea. The vocal cords moved normally and no lesion was present on them.

The patient was calm and at rest, her airway was adequate; any exertion precipitated dyspnea with moderate rib retractions.

She was admitted to MRMC and direct laryngoscopy and biopsy of the subglottic lesion was done under general anesthesia. An indwelling intra-tracheal tube was left in place.

The biopsy was reported to be a moderately well differentiated infiltrating carcinoma of the trachea.

After consultation with my associate, Dr. Paul Davis, it was decided to refer her to the Otorhino-

laryngeal Department at the Medical University of South Carolina in Charleston.

The intra-tracheal tube was withdrawn by the patient and as she did not appear to be in respiratory distress, she was transported by an ambulance to MUSC without an intra-tracheal tube.

While at the MUSC, a CT scan of the neck confirmed the presence of an intra-tracheal mass extending from a few millimeters below the cords for a distance of approximately 6cms. to the level of the thyroid gland.

A needle biopsy of a cervical node was positive for carcinoma. On October 7, 1983, a tracheostomy was done. She made an uneventful recovery and was allowed to return home. She was treated by Dr. A. Woodward with radiotherapy at MRMC and this was completed on January 14, 1984. She received a total of 6,460r. She also received chemotherapy by Michael D. Pavy, M.D.

Her tracheal tube was removed during the latter part of her radiation therapy.

Subsequently, the patient was seen in the Emergency Room at MRMC with marked respiratory difficulties consisting of stridor, rib, and suprasternal retractions. A nasotracheal tube was

inserted in the ER by the anesthesiologist with some difficulty. She was admitted to MRMC and a secondary tracheostomy was done by Dr. Paul Davis and me. She made a satisfactory recovery and was discharged home. She has returned to the office at monthly intervals since then. She was last seen on June 12, 1984 for a change of her tracheal tube. At that time, a large tumor about seven centimeters in diameter was noted in the upper left cervical area. This undoubtedly represents metastasis from her primary tracheal lesion.

COMMENT: Tracheal carcinomas are not common. The relative frequency as compared with the incidence of primary malignant bronchial tumor is probably no greater than two percent.⁴

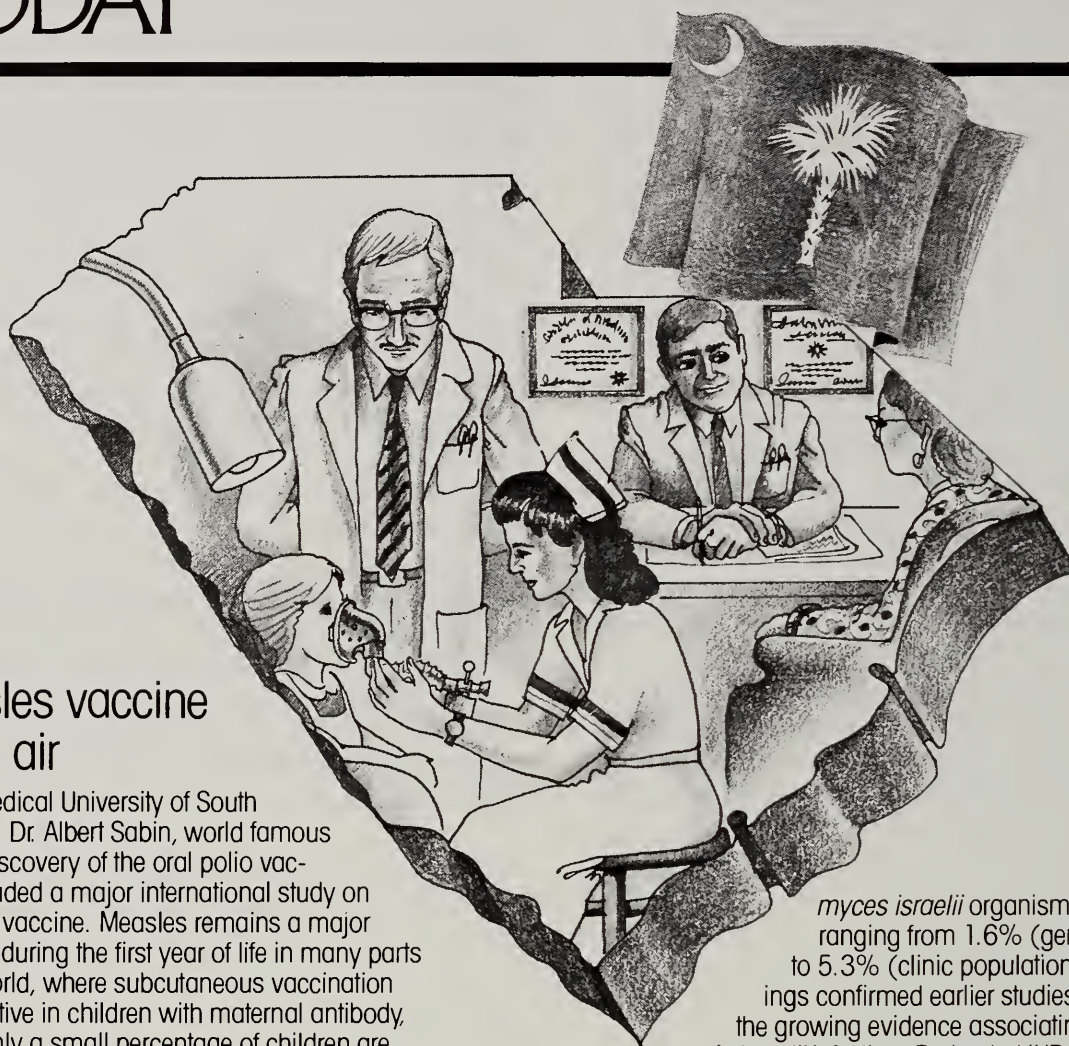
This is the first such case that the senior author has encountered. □

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2. English, GM, editor *Otorhinolaryngology*: Vol. 2, chapter 38, pages 20-27.
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4. English, GM, editor *Otorhinolaryngology*: Vol. 3, chapter 46, pages 34-37.

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SOUTH CAROLINA MEDICINE TODAY



Measles vaccine in the air

At the Medical University of South Carolina, Dr. Albert Sabin, world famous for his discovery of the oral polio vaccine, headed a major international study on measles vaccine. Measles remains a major problem during the first year of life in many parts of the world, where subcutaneous vaccination is ineffective in children with maternal antibody, where only a small percentage of children are routinely vaccinated and where life-threatening secondary bacterial infection is still common.

The Sabin study reported that inhalation of an aerosolized measles vaccine was immunogenic in 100% of children four months and older, whether or not they had residual maternal antibody. There were no significant adverse reactions or contact infections. This indicates that mass immunization by inhalation of aerosolized vaccine has the potential of rapidly eliminating the disease in areas where it continues to be a serious public health problem.¹

Actinomyces prevalent in long-time IUD wearers

In one of the largest prospective studies of its kind, researchers in Charleston found prevalence of *Actino-*

myces israelii organisms in IUD wearers ranging from 1.6% (general population) to 5.3% (clinic population).² These findings confirmed earlier studies and added to the growing evidence associating IUD and *A. israelii* infection. Protracted IUD use appeared to be associated with higher incidence of infection. No *A. israelii* organisms were identified in non-IUD users among a total study population of nearly 70,000 women.

IUD-associated *Actinomyces* colonization appears to produce only superficial infection in the vast majority of cases. If the patient is asymptomatic, conservative management is suggested, including removal of the IUD and repeated Pap smears. However, a JAMA editorial emphasizes that such infections must be taken seriously. "The magnitude of *Actinomyces* infection and its socioeconomic implications can be staggering. Use of IUD especially among nulliparous women, with subsequent tubal scarring, temporary and permanent sterility problems, effect of poor nutrition, and the sudden clustering of IUD-associated *Actinomyces* infection, are only some of the problems with global ramifications."³

References: 1. Sabin AB, et al: JAMA 249:2651-2662, May 20, 1983.
2. Valicenti JF Jr, et al: JAMA 247:1149-1152, Feb 26, 1982. 3. *Actinomyces* in vaginal smears. JAMA 247:1175-1176, Feb 26, 1982.

STRESS: DIFFERENT CONCEPTS FOR DIFFERENT PEOPLE

SYLVESTER R. MLOTT, Ph.D.*

Although stress seems to be a familiar ingredient of modern life, the concept of stress creates difficulty due to the fact the term is used to cover too much territory and its meaning is somewhat vague. In addition, there appears to be considerable variation among adults in the level of emotionality exhibited when under situations of stress or even under relatively innocuous settings.

The literature rebounds with diverse opinions as to the meaning of stress. Kendler¹ defines it as a word we use frequently to describe the effects upon contemporary man of the many disturbing situations in which he finds himself such as making decisions upon which success or failure depend, working long hours, taking various exams, etc. He defines stress as having three components (1) the stressful situation, (2) the physiological changes produced by stress, and (3) the resulting behavior. Munn² states, "When frustration is prolonged and no resolution occurs, there is usually a condition of chronic emotional tension which is referred to as stress. Selye³ defines stress as the bodily changes produced whether a fusion is exposed to nervous tension, physical injury, infection, cold, heat, x-rays or anything else. He proposed the "General Adaptation Syndrome" as a means of explaining the physiological processes that develop when an organism is exposed to a stress situation. Stress provoking agents (or stressors) arise from two main sources according to Selye, (1) from physical conditions that damage the body (starvation, physical injury), and (2) from psychological problems such as intense persistent fear or prolonged unresolved conflict. However, what constitutes a stressor for one individual is not necessarily a stressor to another. Furthermore, although stressors may differ in their origins, it is quite possible to have a common physical reaction occur. Freedman et al.⁴ describe stress as a chronic state of anxiety triggered by some specific stimuli or condition. For instance,

an external event such as loss of job, or an internal conflict such as the desire to be aggressive can be called a stress if the individual is unable to cope with it, or if the nervous reactivity is excessive or prolonged. Along a similar path of explanation is that of Gfeller⁵ who attempts to show the fundamental difference between two often confused concepts, "stress" and "trigger situations" using the example of stress ulcer and the trigger situation leading to the manifestation of the ulcer. The trigger situation is defined as a current situation, a well-defined and specific event that is only conflictual for a very specific personality type. When this conflict reaches a sufficient intensity, the patient's defense system is decompensated and the conflict triggers the system . . . the ulcer attack. Whether an event is stressful or not depends on the nature of the event and on the individual's resources, defenses, and coping mechanism. Freedman describes the reaction to stress as taking place in four overlapping phases (1) the anticipatory of threat phase, (2) the impact phase where variable degrees of personality or group disintegration may occur in a previously well-adjusted person. During this phase the focus is on the immediate present and if the stress is overwhelming in intensity, a state of decreased alertness and disorganization occurs. The third stage is the recoil phase and involves the manifestations of beginning reintegration of adaptive function. The fourth stage is the post-traumatic phase and involves the emotionally charged experiences being assimilated and shared with others. During this last stage, the sense of self has been maximally reconstituted.

STRESS INDUCED SYMPTOM FORMATION

Physiological

The idea that disturbed behavior and bodily reactions occur in response to severely tense environmental conditions is now widely accepted. An early attempt to systematize such relationship was that of Adolf Meyers⁶ life chart which dealt

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with the temporal sequence linking the occurrence of life events and symptoms. More recently, Holmes and Rahe⁹ added to our understanding the qualities that appear casually related to later illness by quantifying the extent of readjustment required by selected events.

It appears that individuals with already established illness or proneness to anxiety tend to react to moderate pain stimulation with greater physiological disturbance in various organ systems than individuals who are free of illness.⁷⁻¹⁴ It has been demonstrated that the physiological system that is particularly responsive to experimental stress is more likely to be one that is habitually involved in the patient's illness, that is, one that produces symptoms.⁴ Rahe¹⁵ presents the view that the stress tolerance an individual evidences is determined by the level of energy available to the individual at the time of the stress situation.

Psychological

Tennant and Andrews¹⁶ have shown that an increase in life event stress occurs prior to the onset of a number of psychiatric illnesses. This relationship was also found for psychiatric admissions to hospitals,⁶ while Mueller et al.¹⁹ found that the relationship of life events to psychiatric symptomatology depended on the degree of threat and/or undesirability associated with the life event. According to these authors, the more threatening or undesirable the event is, the more stress and probability of psychiatric symptomatology. They also feel that since undesirability is a characteristic of life events and stress, it should be measured most accurately in situations to assess their stressfulness. Kahn¹⁷ states the epidemiological evidence clearly indicates that an especially high rate of schizophrenia at the lowest class levels is due to the fact that the conditions of life experienced by people of lower social class foster conceptions of social reality which are so limited and rigid as to impair their ability to deal resourcefully with problems and situations of great stress. Although such impairment does not in itself result in the disabling disorder, its interaction with genetic vulnerability and great stress could be disabling. Harder et al.¹⁸ investigated the relationship among stressful life events, self-derogation, and psychological impairment in outpatients of a community mental health center and found that life events and self-derogation are each associated with impairment. However, life events

do not affect health-sickness via self-derogation. Liem and Liem¹⁹ found individual psychological disorders related to the role of social structure and the support given to the individual. Dressler et al.²⁰ studying subjects with severe emotional crisis found their pre-stress lives were characterized by conflictual interpersonal relationships with a high degree of communicative impairment, few friends, and a lack of success in handling previous stress, ill defined goals, and few areas of life satisfaction or acknowledged achievement. The precipitating stressful event was the final blow in a series of failure experiences. The authors explain the failure of the individual to withstand the precipitating stress due to a low self-esteem traced to a childhood where feelings of unworthiness or having some kind of defect were perceived. An unanticipated finding was the high incidence of interpersonal stress, precipitating events, and the "initiator" role of the person in provoking the emotional crisis. The finding was supportive of the theory held by some investigators that life events are often caused by people rather than just happening to them.

McLean²¹ maintains that depression is a specific response to stress, and that psychological factors (stressors) are responsible for the development, maintenance, and reversal of depression. The author supports his view by stating that the clinical and research data suggest that small everyday stressors (microstressors) act cumulatively, and in the absence of compensatory positive experience can be a strong source of depression. Whether the person becomes depressed or not depends on his or her management of strategies for coping with encountered stress. Ilfield²² explored the relationship of current social stressors (defined as circumstances of daily social roles that are generally considered problematic or undesirable) to depressive symptoms and found them closely related to the social stressors of marriage and parenting, and suggested a therapeutic focus on these areas of stress. Prusoff et al.²³ also suggested the role of specific psychological stressors in the etiology of depressive illness. An analysis of different categories of events showed that events involving withdrawal from social events (exit events), arguments, or financial reverses distinguished the depressed from the nondepressed person. Paykel²⁴ came to similar findings in which life events (particularly exit events and events regarded as undesirable) tend to cluster prior to

the onset of depression. Patients with suicide attempts generally differ from other patients and experience a particularly striking accumulation of threatening events. There is a marked peaking of events in the month before the attempt, suggesting a crisis response and the potential relevance of crisis intervention techniques. Warheit²⁵ also found respondents with high life-event scores having significantly more depressive symptomatology than those with low scores. Respondents possessing personal, familial, and interpersonal resources had significantly less depressive symptomatology than those without such resources. Dunner et al.²⁶ assessed the occurrence of stressful life events before the initial or subsequent episodes of an affective illness, and found their respondents able to recall a life event in the three-month interval before their initial affective episode. Few respondents recalled events for their subsequent episodes.

There appear to be two hypotheses that attempt to explain the relationship between stress (defined as life changes in the recent history of an individual) and prognosis in mental health. The first, based on the reactive-endogenous dichotomy, attempts to explain differential outcomes in both depression²⁷ and psychosis.²⁸ Life changes that act as precipitants toward mental illness are characterized as the reactive forms of these illnesses and are indicators for a good prognosis. The endogenous forms of illness develop incipiently and without precipitating stress and have poor prognosis. The second hypothesis suggests that life changes cumulatively lead to mental illness,²⁹ and that individuals are "stress prone"³⁰ and consequently more prone to repeatedly develop mental illness.

Stress Influence on Hospitalization

Janies³¹ in his studies of surgical patients provided considerable preliminary evidence concerning the positive consequences of a moderate degree of reflective fear in his subjects. Drellich et al.³² observed that patients who remained "care-free" during the preoperative period are more likely to lose emotional control and become panic-stricken when undergoing the stressful experiences that ensue from surgery. It would appear that the arousal of reflective fear prior to the exposure to a stressful life situation is one of the necessary conditions for developing effective inner defenses that enable the person to cope psychologically with stress stimuli. In addition,

persons who showed a relative absence of preoperative fear were more likely than others to display reactions of anger and intense resentment during postoperative convalescence. Volicer and Bohannon³³ recognized that although a moderate degree of stress is good for an individual, too much stress adversely affects the ability of the individual to cope with and recover from the illness. They develop a method for quantifying stress experienced by hospital patients which they called "a Hospital Stress Rating Scale." These authors found that the experience of hospitalization perceived as stressful by patients was primarily related to a lack of communication of information by the hospital staff, e.g., "not being told what your diagnosis is," "not knowing the results or reasons for your treatment," "not having your questions answered," "having nurses or doctors talk too fast or use words you can't understand," and "having the staff be in too much of a hurry." These experiences were rated much more stressful than problems related to eating and sleeping, or other inconveniences of the physical situation. In another study by Volicer³⁴, patients scoring high in hospital stress tended to report more pain, lower physical status during hospitalization, and less improvement after discharge than patients scoring low in hospital stress. It was also found that younger patients experienced higher levels of hospital stress which was explained as being due to financial insecurity (compared to older patients), and worry over separation from spouse and friends. Another explanation for the higher hospital stress in younger patients was that the medical staff found the younger patients similar in age and life situations to themselves. The threat of identifying themselves personally with these patients may result in their spending less time responding to their needs of explaining procedures to them than to older people. The data further suggested that life stress prior to the hospitalization might be an important factor in level of stress experienced because of hospitalization itself, for both medical and surgical patients. Also, those individuals with recent hospitalization reported more stress than others, with seriousness of the illness also a hospital stress factor. Psychosocial stress due to the experience of hospitalization was ascertained by Volicer et al.³⁵ using their Hospital Stress Rating Scale (patterned after the psychosocial method used by Holmes and Rahe)³⁶ which found higher perceived stress

for surgical patients on the dimensions of unfamiliarity of surroundings, loss of independence, and threat of severe illness as well as due to lack of information and financial problems relating to hospitalization.

Implications

In view of what is known about "stress", how can this information benefit the physician and how he deals with his patients? In the course of his daily routine, it becomes apparent that careful scrutiny should be exhibited when a patient verbalizes he "feels stress" or "is under a great amount of stress." Since the definitions of stress are quite varied, and the manner of reacting to

stress equally varied, it becomes extremely important for the physician to fully explore with his patients what is meant when the term "stress" is verbalized. This is likely to involve an in-depth discussion of the type of stress-provoking agent or situation encountered, the physiological changes which were experienced, and the resulting behavior in view of the patients' resources, defenses and coping mechanisms. In addition, the physician should be sensitive to physiological reactions and psychiatric symptomatology that may occur as a result of an increase in life events stress. Skilled intervention by the physician can do much to ward off the symptomatology reflective of stress in his patients. □

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STRESS

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Second Quarter
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Calendar

James M. Long, III, M.D., Chairman

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APRIL

WEDNESDAY-SUNDAY APRIL 24-28

CHARLESTON, Sheraton Charleston

"SCMA's 137th ANNUAL MEETING AND SCIENTIFIC ASSEMBLY"

SPONSOR: South Carolina Medical Association

DESCRIPTION: SCMA's Annual Meeting is offering more than 50 hours of Continuing Medical Education, from which a physician can select up to 21.5 CME hours. AAFP Credit Prescribed for.

AUDIENCE: M.D.'s

FACULTY: Staff and Guest

CONTACT: Donna Murphy, (803) 798-6207

THURSDAY-FRIDAY APRIL 4-5

CHARLESTON, Mills House Hotel

"CURRENT TOPICS IN GASTROENTEROLOGY"

SPONSOR: Department of Medicine, MUSC

DESCRIPTION: Highlight recent clinical advances in Gastroenterology with emphasis on clinical application of newer developments in diagnosis and management of common hepatic and GI problems.

AUDIENCE: M.D.'s

FACULTY: William M. Lee, M.D., Assoc. Professor Medicine, MUSC

CONTACT: A. Cleve Hutson, Jr., M.D., (803) 792-2411

CME CREDIT: 15 Hours AAFP Prescribed

WEDNESDAY-SUNDAY APRIL 10-14

KIAWAH ISLAND, South Carolina

"POSTGRADUATE COURSE IN SURGERY"

SPONSOR: MUSC Department of Surgery

DESCRIPTION: Covers a broad range of general surgical problems from the viewpoint of current established practice.

AUDIENCE: Surgeons

FEE: \$450

FACULTY: Staff and Guest

CONTACT: C.A. Miller, (803) 792-3653

CME CREDIT: 21 Hours AMA Category I 2.1 CEUs

FRIDAY-SATURDAY APRIL 12-13

HILTON HEAD, Cottages Conference Center - Shipyard Plantation

"HYPERTENSION 1985: THERE IS SOMETHING NEW"

SPONSOR: USC School of Medicine and American Heart Association

DESCRIPTION: The participants will have an understanding of what is involved in (1) the proper evaluation of a person with hypertension; (2) the selection of the medicines to be used; and (3) adjustment of management in elderly persons or patients with other disease processes.

AUDIENCE: Primary Care Physicians and Nurses

CONTACT: J. O'Neal Humphries, M.D.; Michael Assey, M.D., (803) 733-3200

FEE: \$100

FACULTY: Guest and Staff

CME CREDIT: 10.5 Hours AMA Category I, 10.5 Hours AAFP Prescribed

MONDAY-THURSDAY APRIL 15-18

HILTON HEAD ISLAND, Sea Pines Plantation

"FAMILY THERAPY FOR THE MENTAL HEALTH PROFESSIONAL"

SPONSOR: Boston University School of Medicine

DESCRIPTION: To improve course each year by addressing needs/suggestions of registrants; to access lectures seminars and workshops

AUDIENCE: Interested Health Professionals

CONTACT: William I. Malamud, M.D., (617) 266-8800

CME CREDIT: 17 Hours AAFP Prescribed

MONDAY-FRIDAY APRIL 15-19

HILTON HEAD ISLAND, Sea Pines Plantation

"CURRENT CLINICAL PEDIATRICS"

SPONSOR: Boston University School of Medicine, Department of CME

DESCRIPTION: Current and latest in treatment (various) of Pediatrics

AUDIENCE: Interested Physicians

CONTACT: Barry M. Manuel, M.D., (617) 247-5602

CME CREDIT: 18 Hours AAFP Prescribed

FRIDAY-SATURDAY APRIL 19-20

COLUMBIA, Columbia Marriott Hotel

"SECOND SOUTH CAROLINA SURGICAL ENDOSCOPY WORKSHOP"

SPONSOR: USC School of Medicine Department of Surgery; Dorn VA Hospital and American Cancer Society South Carolina Division

DESCRIPTION: This course is designed for practicing surgeons who wish to learn the techniques and indications of Esophagogastroduodenoscopy (EGD) and Flexible Sigmoidoscopy. Surgeons who are already familiar with these techniques will have an opportunity for an update in the further application of these procedures as they apply to newer diagnostic and therapeutic maneuvers.

AUDIENCE: Surgeons

CONTACT: Frederick L. Greene, M.D., (803) 776-4000, Ext. 582

FEE: \$225

FACULTY: Staff and Guest

CME CREDIT: 11 Hours AMA Category I

FRIDAY APRIL 26

COLUMBIA, Dorn Veterans' Hospital Auditorium

"NEW TRENDS IN ADDICTIONS"

SPONSOR: University of South Carolina School of Medicine; Dorn Veterans' Hospital and South Carolina Commission on Alcohol and Drug Abuse

DESCRIPTION: The participant will be able to assess possible biochemical factors encouraging addiction; (2) will be able to assess family factors encouraging addiction; (3) will be able to assess addicted persons susceptible to suicidal behavior; (4) will be able to assess the unique problems of addiction in the elderly.

AUDIENCE: M.D.'s, Nurses, Addiction Counselors, Social Workers, Psychologists and other Health Care Personnel

CONTACT: I.R. Elder, PhD; R.T. Harvey, PhD, (803) 776-4000, Ext. 496 or Ext. 688

FEE: \$5.00

FACULTY: Guest and Staff

CME CREDIT: 5.5 AMA Category I, .55 CEU

FRIDAY-SATURDAY APRIL 26-27

CHARLESTON, Marriott Hotel

"PRIMARY CARE OF THE INJURED HAND"

SPONSOR: MUSC Department of Orthopaedic Surgery

DESCRIPTION: To review functional anatomy, general principles of wound treatment and to introduce new methods of treatment through panel discussion of specific injuries.

AUDIENCE: M.D.'s

FEE: \$200

CONTACT: Odessa Ussery, (803) 792-4435

FACULTY: Staff and Guest

CME CREDIT: 9 Hours AMA Category I, .9 Hours CEUs

MAY

THURSDAY-SUNDAY MAY 2-5

HILTON HEAD ISLAND, Hilton Head Inn

"EIGHTH ANNUAL CLINICAL ENDOCRINE SYMPOSIUM — ENDOCRINE ASPECTS OF MAINTAINING HEALTH"

SPONSOR: Division of Endocrinology and Metabolism, University of South Carolina School of Medicine

DESCRIPTION: The program will include three morning Meet-the-Professor breakfast sessions, morning lectures, and two evening workshops.

AUDIENCE: M.D.'s

CONTACT: H.R. Nankin, M.D., (803) 733-3112

FEE: Participants \$225, Spouse/family \$75

CME CREDIT: 16.5 Hours AMA Category I, 16.5 AAFP Prescribed

FRIDAY-SATURDAY MAY 3-4

GREENVILLE, The Hyatt

"ANNUAL MEETING - SOUTH CAROLINA SOCIETY OF NUCLEAR MEDICINE"

SPONSOR: South Carolina Society of Nuclear Medicine

DESCRIPTION: Four hour sessions on Cardiology and Oncology plus other sessions on "Comparing Imaging Modalities," instrumentation and regulations.

AUDIENCE: Technologists

FEE: \$45

CONTACT: Jeanne Edwards, (803) 792-3240

FACULTY: M.D.'s and Nuclear Medicine Specialists

MONDAY-FRIDAY MAY 6-10

HILTON HEAD ISLAND, Sea Pines Plantation

"CONTROVERSIES IN INTERNAL MEDICINE"

SPONSOR: Boston University School of Medicine

DESCRIPTION: To provide the practitioner an opportunity to discuss many current controversies in medicine, take part in workshops on common/controversial areas.

AUDIENCE: M.D.'s

CONTACT: Robert M. Levin, M.D., (617) 424-5429

CME CREDIT: 17.50 Hours AAFP Prescribed

THURSDAY-SATURDAY MAY 9-11

CHARLESTON, Mills House Hotel

"19TH ANNUAL OPHTHALMOLOGY CONFERENCE"

SPONSOR: Albert Florens Storm Eye Institute

DESCRIPTION: The purpose of the Conference is to provide high quality continuing medical education for the ophthalmologist in practice.

AUDIENCE: Ophthalmologists

CONTACT: Maddie Manuel, (803) 792-2492

FEE: \$155

FACULTY: Staff and Guests

CME CREDIT: 10 Hours AMA Category I

THURSDAY-SATURDAY MAY 23-25

CHARLESTON, Sheraton Charleston Hotel

"NINTH ANNUAL UPDATE CARDIOLOGY FOR THE PRIMARY PHYSICIAN"

SPONSOR: MUSC and American College of Cardiology

DESCRIPTION: The intent of this program is to bring the newer modalities of diagnosis and treatment to the primary care physician.

AUDIENCE: FP, IM, GP and Cardiologists

CONTACT: Registration Secretary

(301) 897-5400, Ext. 226

FEE: \$280 for ACC Members; \$335 for Non-members; \$185 for Residents

CME CREDIT: 18 Hours AMA Category I

FACULTY: Staff and Guest

MONDAY-FRIDAY MAY 27-31

CHARLESTON, South Carolina

"SECOND ANNUAL IMAGING AT SPOLETO"

SPONSOR: MUSC Department of Radiology

DESCRIPTION: The seminar is designed to update physicians on newer imaging modalities including ultrasound, pediatric radiology, uro-radiology and nuclear medicine.

AUDIENCE: Radiologists

CONTACT: Paul Ross, M.D., (803) 792-4267

FEE: \$350

FACULTY: Staff and Guest

CME CREDIT: 20 Hours AMA Category I

JUNE

MONDAY-SATURDAY JUNE 3-8

CHARLESTON, Francis Marion Hotel

"SPOLETO UPDATE XI - HEALTH CARE OF THE GERIATRIC PATIENT"

SPONSOR: Family Medicine Department - MUSC

DESCRIPTION: Review major principles of health care for the elderly and update specific clinical topics in geriatric medicine.

AUDIENCE: M.D.'s

CONTACT: Benjamin Goodman, M.D.; Cleve Hutson, M.D., (803) 792-2411

CME CREDIT: 31.25 Hours AAFP Prescribed

MONDAY-THURSDAY JUNE 10-13

KIAWAH ISLAND, Kiawah Island Inn

"INTERNAL MEDICINE - RECENT ADVANCES"

SPONSOR: Medical College of Georgia

AUDIENCE: M.D.'s

CONTACT: Glen E. Garrison, M.D., (404) 828-3998

CME CREDIT: 26 Hours AAFP Prescribed

WEDNESDAY-FRIDAY JUNE 12-15

MYRTLE BEACH, Myrtle Beach Hilton

"DERMATOLOGY FOR NON-DERMATOLOGISTS"

SPONSOR: Duke University Medical Center

DESCRIPTION: An intensive, clinically oriented course designed for family physicians, internists, pediatricians, and general practitioners that will stress current advances in the patho-physiology and therapy of commonly encountered dermatological problems.

AUDIENCE: M.D.'s

CONTACT: Sheldon R. Pinnell, M.D., (919) 684-2504

CME CREDIT: 13.50 Hours AAFP Prescribed

SUNDAY-FRIDAY JUNE 23-28

HILTON HEAD ISLAND, Sea Pines Plantation

"PREVENTION IN PRIMARY CARE: A PROFESSIONAL, PERSONAL AND FAMILY APPROACH"

SPONSOR: Boston University School of Medicine

DESCRIPTION: Will focus on Clinical health maintenance. Also offers a curriculum for those accompanying the health professional. Will feature personal health and risk assessments, computer demonstrations on how to analyze diet and estimate risk.

AUDIENCE: Primary Care Health Professionals, their spouses and children

CONTACT: Joan M. Alterkruse, M.D., PH, (803) 733-3307

Robert M. Levin, M.D., (617) 424-5429

FEE: \$400 M.D.'s; \$125 Spouses; \$25 Children

FACULTY: Staff and Guests

CME CREDITS: 17.5 Hours AMA Category I, 17.5 Hours AAFP Prescribed

GRAND ROUNDS U.S.C. School of Medicine

1st and 3rd MONDAYS 3:00-4:00

GASTROINTESTINAL RADIOLOGY CONFERENCE

COLUMBIA, VA Radiology Dept. Conference IC 209, VA Hospital

SPONSOR: USC School of Medicine, Dept. of Radiology and Gastroenterology and Division of Internal Medicine

DESCRIPTION: One-half of the conference will be a discussion and film review of a specific subject. The second half will be devoted to current case material with both radiographic and endoscopic findings.

AUDIENCE: Radiologists, Gastroenterologist and other interested physicians

CONTACT: James J. Farrell, M.D., (803) 733-3295

FACULTY: USC School of Medicine, Dept. of Radiology; Division of Gastroenterology, Internal Medicine and Guest Speakers

CME CREDIT: 1 Hour AMA Category I per session

MONDAYS 7:00 A.M.

ORTHOPAEDIC GRAND ROUNDS

COLUMBIA, Richland Memorial Hospital - 1st Floor

CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

MONDAYS 4:00 P.M.

BASIC SCIENCES SEMINAR SERIES

CONTACT: Philip Watson, PhD, (803) 733-3242

MONDAYS-THURSDAYS 12:00-1:00 P.M.
INTERNAL MEDICINE LECTURE SERIES
Richland Memorial Hospital 7 West Classroom
CONTACT: J. O'Neal Humphries, M.D., (803) 765-6563

2st & 3rd MONDAYS 12:30 P.M.
G.I. JOURNAL CLUB
Dorn Veterans' Hospital Room 5A127
CONTACT: John Orchard, M.D., (803) 776-4000 Ext. 673

MONDAYS, TUESDAYS, & THURSDAYS 12:00-1:00 P.M.
FAMILY PRACTICE CONFERENCE
COLUMBIA, Richland Memorial Hospital, Large Dining Room of the Cafeteria—Mondays—Family Practice Conference Room—Tuesdays and Thursdays
SPONSOR: Dept. of Family Practice, USC School of Medicine
AUDIENCE: Family Practice and Internal Medicine Physicians and Medical Students
CONTACT: Roslyn D. Taylor, M.D., (803) 765-6118, Dept. of Family Medicine Richland Memorial Hospital, Columbia, SC
FACULTY: Dept. of Family Medicine and Internal Medicine, USC School of Medicine
CME CREDIT: 1 Hour AMA Category I per session

TUESDAYS 7:00 A.M.
BASIC SCIENCE & PATHOLOGY ASPECTS OF ORTHOPAEDICS
Richland Memorial Hospital - Radiation Therapy Conference Room
CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

2nd & 4th TUESDAYS 12:00 NOON
PATHOLOGY G.I. CONFERENCE
Dorn Veterans' Hospital, Room 1A172
CONTACT: John Orchard, M.D., (803) 776-4000, Ext. 673

3rd TUESDAYS 12:30 P.M.
OB/GYN GRAND ROUNDS
COLUMBIA, Richland Memorial Hospital
SPONSOR: USC Dept. of OB/GYN, RMH, MUSC, Spartanburg and Greenville
DESCRIPTION: One of a series of live interactive broadcasts over the HCN, a statewide closed circuit TV network for CME in OB/GYN.
CONTACT: Ronald B. Wade, M.D., (803) 765-7156
FEE: None
CME CREDIT: 1 Hour AMA Category I (per session)

1st, 2nd & 4th TUESDAYS 1:00 P.M.
PEDIATRIC GRAND ROUNDS
COLUMBIA, Richland Memorial Hospital
SPONSOR: USC School of Medicine, Dept. of Medicine
CONTACT: Warren Derrick, M.D., (803) 765-7211
CME CREDIT: 1 Hour AMA Category I (per session)

WEDNESDAY 12:00 NOON
PSYCHIATRY GRAND ROUNDS
Hall Institute Form
CONTACT: Bonnie Ramsey, M.D., (803) 758-8052
CME CREDIT: 1 Hour AMA Category I (per session)

2nd & 4th WEDNESDAYS 12:00 NOON
PULMONARY MEDICINE CHEST CONFERENCE
Richland Memorial Hospital, 7th Floor Conference Room

1st & 3rd THURSDAYS 12:00 NOON
3rd Floor Conference Room, Dorn Veterans' Hospital
CONTACT: Gerald N. Olsen, M.D., (803) 733-3112

WEDNESDAYS 6:00 P.M.
ORTHOPAEDICS PROBLEM CONFERENCE
Richland Memorial Hospital Conference Room "P", ACC II
CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

THURSDAYS 10:00 A.M.
HEMATOLOGY/ONCOLOGY GRAND ROUNDS
Dorn Veterans' Hospital, 5-West Classroom
CONTACT: George P. Satiano, M.D., (803) 733-3112

4th THURSDAY 12:00 NOON
G.I. RESIDENTS CONFERENCE
Dorn Veterans' Hospital, 4th Floor Conference Room
CONTACT: John Orchard, M.D., (803) 776-4000, Ext. 673

1st THURSDAYS 4:00 P.M.
RADIOLOGY DEPT. CONTINUING EDUCATION CONFERENCE
USC School of Medicine Library Bldg., Room B-116
CONTACT: David F. Adcock, M.D., (803) 733-3295
CME CREDIT: 1 Hour AMA Category I

THURSDAYS 4:00 P.M.
ENDOCRINE CASE PRESENTATION
USC School of Medicine Administration Bldg. 2nd Floor Conference Room
CONTACT: Juraj Osterman, M.D., (803) 733-3112

FRIDAYS 7:00 A.M.
ORTHOPAEDIC SUB-SPECIALTY TOPICS
Richland Memorial Hospital - Large Private Dining Room
CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

FRIDAYS 9:00-11:30 A.M.
PREVENTIVE MEDICINE GRAND ROUNDS
USC School of Medicine Library Bldg. Room 327
CONTACT: Alan Chovil, M.D., (803) 733-3306
CME CREDIT: 2 Hours AMA Category I

FRIDAYS 1:00 P.M.
INTERNAL MEDICINE GRAND ROUNDS
COLUMBIA, Richland Memorial Hospital Auditorium
SPONSOR: Dept. of Medicine, USC School of Medicine
AUDIENCE: Internal Medicine and Family Practices Physicians
CONTACT: J. O'Neal Humphries, M.D., Chairman, Dept. of Medicine, (803) 765-6563
CME CREDIT: 1 Hour AMA Category I

SATURDAYS 9:00-10:00 A.M.
SURGICAL GRAND ROUNDS
COLUMBIA, Richland Memorial Hospital Auditorium
SPONSOR: USC School of Medicine, Dept. of Surgery
DESCRIPTION: Lectures and case presentations given by the department staff and guest speakers
AUDIENCE: Faculty, Residents, Students and Private Clinicians
CONTACT: Carl H. Almond, M.D., (803) 254-4158; James L. Haynes, M.D., (803) 765-7452; Frederick L. Greene, M.D., (803) 776-4000, Ext. 582
FACULTY: Staff of Dept. of Surgery and guest lecturers
CME CREDIT: 1 Hour AMA Category I (per session)

GRAND ROUNDS

Medical University of South Carolina

MONDAYS 9:30 A.M.
PATHOLOGY - Surgical Pathology Conference
CONTACT: Drs. Betsill, Garvin, and Metcalf, (803) 792-3821

EACH MONDAY 12:00 NOON
UROLOGY - Clinical Sciences Bldg. Suite 644
CONTACT: Dr. Stepheyn N. Rous, (803) 792-4531

MONDAYS 12:30-1:30 P.M.
RADIOLOGY - Noon Conference
CONTACT: Dr. E.Q. Seymour, (803) 792-4261

MONDAYS 4:00-5:00 P.M.
RADIOLOGY - Special Imaging Conference
CONTACT: Dr. E.Q. Seymour, (803) 792-4261

EVERY OTHER MONDAY 10:00 A.M.-12:00 NOON
PATHOLOGY - Pathology Microscopic Round Table Conference
CONTACT: Dr. Gordon Hennigar, (803) 792-3121

MONDAY-FRIDAY
RADIOLOGY - Visiting Radiologist
CONTACT: Dr. E.Q. Seymour, (803) 792-4261

TUESDAYS 7:00 A.M.
SURGERY - Cancer Conference/Surgical Grand Rounds
CONTACT: Drs. Anderson and O'Brien, (803) 792-3361 or 3276

TUESDAYS 7:00-8:00 A.M.
ORTHOPAEDIC SURGERY - Orthopaedic Grand Rounds
CONTACT: Dr. John B. McGinty, (803) 792-3934

TUESDAYS 8:00-10:00 A.M.
PATHOLOGY - Seminar-Tutorial Group Sessions, Systemic Path.
CONTACT: Dr. Jane Upshur and Dr. Gordon Hennigar, (803) 792-2456

TUESDAYS 8:30-9:30 A.M.
OB/GYN - Morning Conference
CONTACT: Dr. Peter Van Dorsten, (803) 792-2684

TUESDAYS 9:00-10:00 A.M.
MEDICINE - Medical Grand Rounds
CONTACT: Dr. Jon J. Levine and Dr. James Allen, (803) 792-2528

TUESDAYS 11:00 A.M.-Noon
LABORATORY MEDICINE - Laboratory Medicine Case Presentation
 CONTACT: Elena Prevost, (803) 792-3937

TUESDAYS 11:00 A.M.-NOON
PSYCHIATRY - Departmental Grand Rounds
 CONTACT: Dr. R.R. Mellette, Jr., (803) 792-4037

TUESDAYS 12:30-1:30 P.M.
OB/GYN - TV Grand Rounds
 CONTACT: Julia Day, Division of Continuing Education, (803) 792-4435

TUESDAYS 1:00-2:00 P.M.
PATHOLOGY - OB/GYN Pathology
 CONTACT: Dr. John Metcalf, (803) 792-4050

TUESDAYS 2:00-3:00 P.M.
PSYCHIATRY - Case Conference
 CONTACT: Dr. Thomas Steele, (803) 792-4050

TUESDAYS 4:00-5:00 P.M.
PATHOLOGY - Orthopaedic Pathology Conference
 CONTACT: Dr. A.J. Gavin, (803) 724-2258, Ext. 2260

TUESDAYS 4:00-5:00 P.M.
SURGERY - Surgical Seminar Series
 CONTACT: Dr. Max S. Rittenbury, (803) 792-3251

1st & 3rd TUESDAYS 4:00-5:00 P.M.
PATHOLOGY - Gastrointestinal Pathology Conference
 CONTACT: Dr. Francis M. Brown, (803) 577-5011, Ext. 566

2nd & 4th TUESDAYS 1:30-3:00 P.M.
PSYCHIATRY - Case Conference/VA
 CONTACT: Dr. James D. Sexauer, (803) 577-5011, Ext. 234

2nd & 4th TUESDAYS 4:00-5:00 P.M.
PATHOLOGY - Renal Conference
 CONTACT: Dr. Sterling K. Ainsworth, (803) 792-4171

WEDNESDAYS 9:00-10:00 A.M.
PATHOLOGY - Graduate Medical Education in Pathology
 CONTACT: Dr. Gordon Hennigar, (803) 792-3121

WEDNESDAYS 12:10-1:10 P.M.
FAMILY MEDICINE - Family Medicine Noon Conference Series
 CONTACT: Dr. Ben Goodman, (803) 792-2411

WEDNESDAYS 1:00-2:00 P.M.
LABORATORY MEDICINE - Clinical Pathology Conference/VA
 CONTACT: Dr. Jerome L. Sullivan, (803) 577-5011, Ext. 466.

WEDNESDAYS 3:00-4:00 P.M.
LABORATORY MEDICINE - Hematology Conference
 CONTACT: Rebecca E. Reynolds, MT(ASCP)SH, (803) 792-2933

WEDNESDAYS 3:00-4:00 P.M.
PATHOLOGY - Charleston Veterans Administration Medical Center
 Tumor Board
 CONTACT: Dr. Helen M. Dodds, (803) 577-5011, Ext. 466.

WEDNESDAYS 6:00-7:00 P.M.
RADIOLOGY - Low Country Ultrasound Society
 CONTACT: Dr. Stephen I. Schabel, (803) 792-4261

WEDNESDAYS 7:30-8:30 P.M.
OB/GYN - Monthly Journal Club Meeting
 CONTACT: Dr. Oliver Williamson, (803) 792-2864

Last WEDNESDAY of the month 9:00-11:00 A.M.
PATHOLOGY - Grand Rounds
 CONTACT: Dr. J.D. Balentine, (803) 792-3581

THURSDAYS 8:30-10:00 A.M.
PSYCHIATRY - Medicine Teaching Case Conference, Consult/
 Liaison Service
 CONTACT: Dr. Oliver Bjorksten, (803) 792-2971

THURSDAYS 8:30-9:30 A.M.
PATHOLOGY - Surgical Pathology Conference
 CONTACT: Drs. Betsill, Garvin and Metcalf, (803) 792-3821

THURSDAYS 8:30-10:00 A.M.
PSYCHIATRY - Psychiatry Youth Conference
 CONTACT: Dr. Donald J. Carek, (803) 792-3051

THURSDAYS 8:30-9:30 A.M.
RADIOLOGY - Teaching Conference in Neuroradiology
 CONTACT: Dr. Paul Ross, (803) 792-4267

THURSDAYS 9:30-10:30 A.M.
NEUROSURGERY - Neurosurgery Clinical Conference
 CONTACT: Dr. P. Perot, (803) 792-2421

THURSDAYS 9:30-10:30 A.M.
SOCIAL WORK - Pediatric Burn Team Meeting
 CONTACT: Elena Bell, (803) 792-3846

THURSDAYS 10:30-11:30 A.M.
NEUROLOGY - Neurology Grand Rounds
 CONTACT: Dr. Edward L. Hogan, (803) 792-3221

THURSDAYS 10:30-11:45 A.M.
NEUROSURGERY - Neurosurgery Lecture
 CONTACT: Dr. P. Perot, (803) 792-2421

THURSDAYS 12:10-1:10 P.M.
FAMILY MEDICINE - Family Medicine Grand Rounds
 CONTACT: Dr. Ben Goodman, (803) 792-2411

THURSDAYS 1:00-2:00 P.M.
PATHOLOGY & DERMATOLOGY - Dermatopathology Conference
 CONTACT: Dr. John C. Maize, (803) 792-5858

THURSDAYS 4:00-5:00 P.M.
SURGERY - Junior House Officer Conference
 CONTACT: Dr. Marion C. Anderson, (803) 792-3961

1st or 2nd THURSDAYS 11:45-12:45 P.M.
PATHOLOGY - Neuropathology Conference
 CONTACT: Dr. J. Douglas Balentine, (803) 792-3581

2nd, 4th & 5th THURSDAYS NOON
FAMILY MEDICINE - Noon Conference
 CONTACT: Dr. Ben Goodman, (803) 792-2411

MONTHLY 2:30-3:30 P.M.
LABORATORY MEDICINE - Immunohematology Journal Club
 CONTACT: Margaret J. Simmons, MT(ASCP) and Mary A. Spivey, MT
 (ASCP)SBB, (803) 792-2671

FRIDAYS 8:30-10:00 A.M.
MEDICINE/ENDOCRINOLOGY - Endocrinology Journal Club/
 Endocrinology Research Conference
 CONTACT: Dr. Maria F. Lopes-Virella, (803) 792-2528

FRIDAYS 8:30-9:30 A.M.
PATHOLOGY - Surgical Pathology Conference
 CONTACT: Drs. Betsill, Garvin, and Metcalf, (803) 792-3821

FRIDAYS 8:30-9:30 A.M.
PEDIATRIC - Pediatric Grand Rounds/Case Conferences
 CONTACT: Dr. Milton Westphal (803) 792-2113 and Dr. Ashby Taylor,
 (803) 792-3291

FRIDAYS 10:00-11:30 A.M.
PSYCHIATRY - Teaching Case Conference, Adult Inpatient
 CONTACT: Dr. Gordon Trockman, (803) 792-3051

FRIDAYS 12:00-1:00 P.M.
PATHOLOGY - Clinico-Pathologic Conference
 CONTACT: Dr. R.A. Harley, (803) 792-4444

FRIDAYS 12:10-1:10 P.M.
FAMILY MEDICINE - Noon Conference Series
 CONTACT: Dr. Ben Goodman, (803) 792-2411

FRIDAYS 1:00-2:00 P.M.
LABORATORY MEDICINE - Clinical Microbiology Conference
 CONTACT: Dr. John Manos, (803) 792-2984

FRIDAYS 4:00-5:00 P.M.
SURGERY - Surgical Services Conference
 CONTACT: Dr. Marion C. Anderson, (803) 792-3961

FRIDAYS 4:00-5:30 P.M.
MEDICINE/ENDOCRINOLOGY - Endocrinology Case Conference
 CONTACT: Dr. J.A. Colwell, (803) 792-2528

SATURDAYS 9:00-10:00 A.M.
SURGERY - Cancer Conference
 CONTACT: Dr. Paul O'Brien, (803) 792-3276

SATURDAYS 10:00-11:00 A.M.
SURGERY - Surgical Grand Rounds
 CONTACT: Dr. Marion C. Anderson, (803) 792-3961

Editorials

The following is the seventh and last in a series of articles on DRGs. Thanking the various contributors of this informative series, we welcome comments from our readership. Guest editorials express the opinions of the authors and may not necessarily represent the opinions of the Editorial Board and the South Carolina Medical Association.

— CSB

DRGS, FREEZES, DEFICITS AND FREEDOM

At the start of 1984, Charles S. Bryan, M.D., initiated a series of editorials on Diagnosis Related Groups (DRGs) and guest writers have appraised the impact of that dreadful subject on medicine from several points of view. Even two contributors writing in another series chose the impact of DRGs on medical education as their topic. Having read and re-read those editorials in preparation for writing this one, it is apparent that not much good has been said about the system.

DRGS

I am told that the original studies which spawned the DRG system of reimbursement to hospitals for inpatient care grew out of a statistical analysis of surgical admissions of individuals of non-Medicare age — in other words, a group of individuals who were hospitalized with only one illness and a well-defined surgical treatment for it, utilizing a predictable quantity of hospital resources. By using set payments for these groups of surgical diagnoses, the carrot of making money through efficiency was dangled before hospital administrators. Unfortunately, a debt-ridden federal government, in its zeal to save dollars, saw fit to invoke this system of payment as the law for hospitalized Medicare beneficiaries, a group whose patterns of illness are at considerable variance from the original study group of younger people with a single surgically treatable illness. It is the old story of comparing apples and oranges.

The first retort from the defenders of the system is that there is a separate DRG for the complicated case. But those of us who treat the elderly know full well that the \$200 to \$400 differential between the DRG-uncomplicated and the DRG-complicated or over 70 years is not going very far in paying for the treatment required when a patient who was admitted with a fractured femur has a pulmonary embolus just days short of being discharged. The involved system of evaluating cases as outliers by law can give relief in only six percent of the cases reviewed. There is no mecha-

nism of reimbursement for a second illness occurring after admission.

It would seem that the federal government reneging on payment for services received by Medicare recipients is bad enough, but worse still is that portion of the law which deprives hospitals of the *freedom* to recoup losses from those individuals who can afford to pay the difference or from other insurance carriers who have contracted with their policyholders to pay the difference. It is my understanding that the only billing hospitals are allowed beyond the DRG payment is the deductible and the difference between a semi-private and private room. It is no wonder that if one watches TV for about an hour, he is likely to see a commercial selling Medicare supplementary insurance; these companies have the comfort of the limits of their liabilities set in federal statutes.

Hospitals are free to make up their inpatient Medicare losses by raising charges for outpatient services and to non-Medicare inpatients. Can't you just picture the Secretary of Defense telling Lee Iaccoca, "Lee, Chrysler has got to sell us 10,000 tanks and other vehicles at ten percent less than it costs to make them, but don't worry; you are free to pass your losses on to purchasers of Imperials and Dodge Ram trucks." Or can you imagine an edict going out to the supermarket chains requiring that food stamps be redeemed at wholesale or below rather than at present full retail value for goods.

FREEZES

DRGs deal with Part A of Medicare (hospital inpatient reimbursement) which was enacted into law in 1965 without any accompanying tax legislation to fund it. It was merely a tacked on Social Security benefit paid for by federal monies. Part B of Medicare (physician payment), however, carried with it funding legislation in that recipients pay a premium and thereby through those

monies, deductibles and co-insurance defray much of their cost of physician care.

The 15-month freeze on physician's fees has now been in effect since July 1, 1984, as part of the Deficit Reduction Act. We all had to make the decision by October 1, 1984 whether to sign an agreement accepting Medicare assignment in 100 percent of the cases, thereby surrendering some of our *freedom*, or not sign and continue to accept assignment on an individual basis and have some of our *freedom* taken from us. Now there is talk of extending the freeze, but actually it has been extended all along. The fee level at the time of the freeze on July 1, 1984 had been in effect in most instances since January 1, 1984, when most physicians complied with the AMA request to hold the line and not raise fees. When the freeze ends on October 1, 1985, any increase must be in effect on claims made for one calendar year from January 1, 1986 through December 31, 1986, before a portion of it will be allowed on the next fee profile update on July 1, 1987. The duration of time from January 1, 1984 to July 1, 1987 is three and one-half years — it is called a 15-month freeze. Maybe someday I will understand the *new* math.

The fee freeze seems hard to justify since it places the physician in the position of being unable to deal with the inflationary increases to which his practice is subject. Especially hard hit is the primary care physician whose overhead might be as much as 50 percent of his charged fee (even a greater percentage of the Medicare allowable) because he is furnishing the setting and the ancillary personnel required to render a service. Since the inception of Medicare in 1965, I have observed the cost of an office visit increasing four-fold, from \$5.00 to \$20.00. That hasn't even kept pace with the increase in the cost of government services. In 1965, a stamp to mail a bill cost 3¢; a seven-fold increase priced that stamp at 20¢ in 1984 and it has recently gone higher.

It appears that those physicians who perform services or procedures which have evolved from technology developed after the inception of Medicare will not fare as badly under the freeze because much of that fee structure was established after the inflationary spiral was well fixed and, therefore, not penalized by a preinflationary base line. Also, in many instances such services or procedures are performed in the hospital setting, relieving that physician of the overhead expense of setting, ancillary personnel, and even the cost of the highly technical equipment he uses.

DEFICITS

As bad as DRGs and fee freezes may seem, even more awesome is an accumulated national debt of one trillion dollars and an annual deficit in the range of 200 billion dollars. It is readily apparent that DRGs and fees are already being paid with money the federal government does not have. Obviously, something has to be done. It is understandable that government must legislate limitations on health care spending, but must such legislation also restrict the *freedom* of providers of health care. It is utopian, I know, but why can't the government tell its beneficiaries, "We can't pay it all, but we can pay this much and the rest is between you and your physician." If the service was good, the fee reasonable, and the patient is able to pay the difference, you can bet he will. If the service was poor or the fee unreasonable, grievance committees of organized medicine should deal with the errant physician. And finally, those unable to pay the difference should be reassured by having been cared for by a charitable physician sensitive to their financial situation. The good doctor/patient relationship usually works. Fairness and charity come from within — not from legislation.

FREEDOM

The Constitution did not guarantee good health or access to health care, and it is a noble thing for the Congress of our times to extend it to an aging population robbed of financial dignity by inflation. The Constitution does guarantee *freedom*, but somehow with all of this there seems to be a little less of it. Government spending must be brought under control in all areas. We in medicine seem to have had our share of controls through the years with UR (Utilization Review), CON (Certificate of Need), PSRO, PRO, HSA, and now DRGs and frozen fees. The future holds a definite possibility of even more distasteful intrusion on our *freedom*, such as physician DRGs or mandatory assignment. In the past 20 years we have seen great changes in the health care field, and even now there is much talk of PPOs and HMOs, and so forth. Change is always interesting. Sometimes it is for the better; sometimes it is for the worse; sometimes it's just different.

E. MIMS MOBLEY, JR., M.D.
1123 Spring Street
Greenwood, S. C. 29646

FOND MEMORIES OF EMMETT

Orthopedists are among the most likeable of physicians. They tend to be friendly, energetic, positive, pragmatic. They seem to argue among themselves more than most of us — sometimes coming close to exchanging blows — but they are quick to forgive and forget. Perhaps they appreciate, better than the rest of us, both the toughness and the frailty of human tissue.

Emmett was among the most likeable, not only of orthopedists, but of men. Driving up in his old car or bouncing down the corridor in his scrub suit, waving “Hello, Sir!” to everyone he met, he made the day a little bit brighter. Emmett had a unique way of treating all people alike yet making each feel special. A recently-arrived resident related to his wife how, in the course of a frequently-tense morning conference, a slightly balding man of medium height would quietly enter the room, sit in a corner, and proceed to make eye contact with every person in the room, affirming each in turn with a knowing wink or hand wave. The resident told his wife: “I don’t know who that guy is yet!” Later he learned that the stranger was in fact the most famous person in the room: Dr. Lunceford.

One could easily have worked alongside Emmett for years and yet be unaware of his national and international reputation. He didn’t advertise. The casual visitor to his operating room might have mistaken him for an orderly, for he often helped mop the floor between cases. However, orthopedists came from all over the country to learn his methods. His correspondence was worldwide. Characteristic of his modesty, he called his porous-metal hip implant simply “the AML system.” Only later did many of us learn that “AML” stood for Austin Moore-Lunceford.

One can envision that Emmett, having neared the pinnacle of success, might easily have moved his practice to Manhattan, living out his life in expensive three-piece suits, operating on the failed hips of the rich and powerful, allowing the world to come to him rather than vice versa. But that, of course, would not have been Emmett. With his cowboy hats, his plain metal office desk, his frankness, Emmett was the quintessential democratic man, sharing his gifts with everyone.



EMMETT M. LUNCEFORD, JR., M.D.
July 22, 1930-January 17, 1985

He continued to spend one morning each week at a Veterans Administration hospital, operating for a pittance. I shall not forget that my last consultation with him, on the day of his death, concerned a Medicaid patient referred to him for infected non-union of the tibia.

The most remarkable aspect of Emmett’s career is that, as a private practitioner, he achieved excellence in all three areas of medicine — service, teaching, and research. Even among full-time academicians, the “triple threat” is now a rare commodity; tenure committees now insist on excellence in only two of the three areas. Emmett became not only a consummate surgeon and skilled office physician but also a splendid teacher and gifted experimentalist. Residents praised both his ability to coach them through the most difficult operations without losing time or taking over and also his ability to correct mistakes without damaging self-esteem. Always seeking a better way, taking on new projects, he held appointments and tapped the expertise at three of our institutions — Clemson, USC, and MUSC. Recognizing his excellence, national societies elected him to offices usually reserved for full-time academic department chairmen.

The key to Emmett's enormous success was his incredible energy. He was indefatigable. He worked from well before dawn to well after dusk and still found time for his family and his community. There is a story that after undergoing surgery himself, he climbed down from the table and made rounds. He was quite possibly the closest thing to the legendary John Hunter to ever cross the piedmont of South Carolina. Even Hunter would have envied Emmett's amazing ability to combine perpetual motion with calm detachment. On one occasion, Emmett spent two hours preparing a delicate bone graft only to have a scrub nurse drop the graft onto the operating room floor. Before setting out to prepare a new one, Emmett's only response was "Oh, jeepers!"

His energy, in turn, must have been due in large measure to his positive attitude. He was never known to say anything negative about anyone, much less criticize a colleague. He was always moving forward, seeking to better the situation. In

eastern Tennessee, they are still talking about how he managed to thread his crippled Cessna, despite the sleet and snow, through a heavily populated area, somehow missing the girls' dormitory, somehow finding the parking lot, surely saving the lives of many. Until the very end, he was positive, helping others.

Kirsopp Lake, the British theologian, once remarked that "faith is not belief in spite of evidence, but life in scorn of consequence." Most of us fail to realize our full potential because of various doubts — fears of real or imagined consequences. Emmett, putting aside whatever doubts he may have had, doing so much for so many during his allotted time, remains an inspiration. His wife, Caffie, recalled two aphorisms by which he lived: "I only worry about things that are important;" and "If I can't do anything about it, I don't worry about it." Like scores of others, I think that I am a better person for having known Emmett.

— CSB

EMMETT: A MEMORIAL

Emmett M. Lunceford, Jr., in the opinion of his friends and close observers, possessed a truly unique complex of clinical skills and warm, loving, supportive relationships with his patients and peers; and an innovative, quizzical mind filled with ideas; and the interest, ability, and self-sacrifice necessary to make true meaningful advances in implant and other aspects of orthopaedic surgery. Though he traveled far, he always returned home to his wife Caffie, his family, his practice, and his patients. Emmett always loved the University of South Carolina and its athletic teams. This love led him to his final flight.

These facts convince us that Emmett Lunceford's life and accomplishments must be memorialized and guide us towards the form of memorial that would be pleasing to Emmett and appropriate to his life. Certainly, his family must be considered. Caffie Lunceford believes the requisites are:

- I. Emmett M. Lunceford's name be included in the title;

- II. That the memorial be held intact and only income used;
- III. That the memorial be administered and controlled by a Board representing:
 1. Emmett's family.
 2. Emmett's friends and fellow workers.
 3. A member of the faculty, Department of Orthopaedics, USC School of Medicine.
 4. A member of the Moore Clinic.
 5. A representative of the orthopaedic manufacturing industry.
 6. A member of the faculty at USC or perhaps a member of the Board of Trustees at USC.
 7. A member of the Austin T. Moore family.
- IV. That the memorial must concentrate on orthopaedic research, preferably and principally at the University of South Carolina School of Medicine, Department of Orthopaedic Surgery.

Austin T. Moore (1899-1963) pioneered prosthetic hip design and surgery, modifications of

which have led to the flourishing field of replacement surgery today. Dr. Moore was the mentor, idol, chief stimulator, and long associate of Dr. Lunceford. It is therefore deemed appropriate to name the honored chair the Emmett M. Lunceford/Austin T. Moore Chair of Orthopaedic Research. In fulfillment of this, Dr. James B. Holderman, President of the University of South Carolina, on January 21, 1985, created the Emmett M. Lunceford/Austin T. Moore Chair of Orthopaedic Research. The University has agreed to furnish annual professor stipend, research space, expenses, and other accoutrements pertaining to that position. The memorial income, only on the direct advice and consent of the Chair's

Administrative Committee, will be dispersed by the Provost of the University of South Carolina to further orthopaedic research, with such means as salary supplement and research facilitation for the Lunceford/Moore Chair holder. Maximal possible contributions to enhance this chair are solicited at this time. Checks should be made payable to the University of South Carolina Educational Foundation, Lunceford/Moore Chair of Orthopaedic Research specified, and sent to Lunceford/Moore Chair, Suite 401, 3321 Medical Park Road, Columbia, South Carolina 29203.

EDWARD E. KIMBROUGH, M.D.
Editor Emeritus

LETTERS TO THE EDITOR

To the Editor:

Lam and Amidon, in your July 1984 issue, restate the obvious. Physicians necessarily are college graduates, ages 25 and above. Physicians necessarily earn personal per capita income significantly greater than the population mean, median and mode. The expected strong association between these two variables and physician:population ratio is not unlike the expected strong association between the two variables, high temperature and extended daylight and the quality of a day in August. The authors' suggestion, however, that population composition and medical consumption patterns be studied has merit. Possibly, South Carolina can implement a state Health Service Corps to alleviate the need in counties such as Berkeley, Jasper, Clarendon, and Allendale which are designated as Primary Care Health Manpower Shortage Areas and counties such as Orangeburg, Colleton, and Barnwell which are designated as Medically Underserved Areas.

Sincerely,
Andrew F. Clearie, MSPH
Director for Planning and Data
Palmetto Lowcountry Health
Systems Agency, Inc.
P. O. Drawer 1946
Summerville, S. C. 29484

Mr. Clearie's letter was referred to the authors, whose response is as follows:

Andrew F. Clearie's criticisms of our work miss their mark. In our article, we made no statement about physicians' mean income, nor their educational accomplishments. What we did say was, "The regression analysis showed that urban population, and per capita personal income are the three variables principally associated with physician/population ratio." What this means is that these demographic variables are associated with the ratio, not physicians. This distinction, not perceived by Mr. Clearie, is important.

We are interested in isolating and explaining associations between relevant independent variables and physician/population ratios. As matters stand, a community's "urbanness," the proportion of college graduates in its population, and community per capita income explain 50 percent of the variance among South Carolina's communities herein examined.

The severity of physician maldistribution is suggested in the data provided us through the S. C. Cooperative Health Statistics System, *Physicians-Medical and Osteopathic*, 1980. Granting that a physician/population ratio is simplistic, it is at least a sure starting point: to the extent we can explain some part of the remaining variance (involving population morbidity, physician productivity, and consumption patterns), we shall all

better understand how to improve accessibility to physician care for all South Carolinians.

Sincerely,
Roger L. Amidon, Ph.D.
Matthew Lam, M.P.H.
University of South Carolina
Columbia, S. C. 29208

To the Editor:

I have just received a copy of your editorial, "Hypertension in South Carolina: A Small Ray of Optimism," which appeared in the December 1984 issue of the *Journal*. As one of the Co-Principal Investigators of the South Carolina High Blood Pressure Control Project, I want to thank you for highlighting the results of the Carolina Health Survey and the need for cooperation be-

tween public and private sectors for effective control of high blood pressure.

Our working relationship with the South Carolina Medical Association has indeed been a productive one, and we look forward to a continuing cooperative approach in addressing major health problems affecting the citizens of our state. Thanks again for your kind words and for your help in facilitating our communication with the medical community.

Sincerely,
Frances C. Wheeler, Ph.D.
Director
Division of Chronic Disease
DHEC, P. O. Box 2202
Columbia, S. C. 29202



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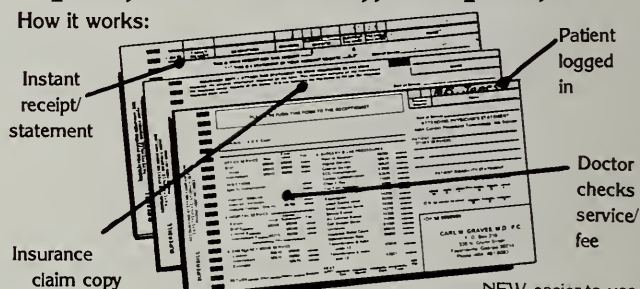
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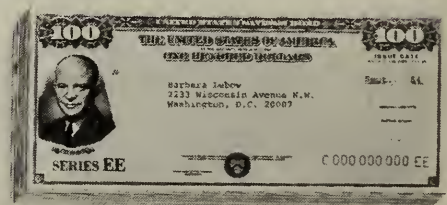


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FINANCIAL CHECKUP

MARTIN LEFKOWITZ
Certified Financial Planner
Tax Shelter Co-Ordinator: E.F. Hutton

Vol. 4, Issue No. 3

March 1985

THE GREAT TAX BATTLE OF 1985

OR: Why is tax simplification so complex?

Presently, there are some 14 tax reform proposals already on the table and the Administration's recommendations yet to come. As yet, it's too early to predict what, if any, reforms will be enacted or within what time frame. For better or worse, 1985 is bound to be a year when tax reform will be a major topic in the news and on the mind. What follows is an overview of the major pending proposals and Hutton's analysis of the impact they are likely to have.

THE REFORM INITIATIVE/SPECIFIC REFORMS.

Three plans represent the major thrust of proposed tax reforms. These are the Republicans' Fair and Simple Tax, known as the Kemp-Kasten Bill after its sponsors, Rep. Jack Kemp (R-NY) and Sen. Bob Kasten (R-WI), the Democrats' Fair Tax Act, or the Bradley-Gephardt Bill, so named for sponsors, Sen. Bill Bradley (D-NJ) and Rep. Dick Gephardt (D-MO), and the Treasury Department's proposal..... Each of the major reform packages is a variation on the "flat tax" theme. Under a pure flat rate tax, all taxpayers would be assessed at the same rate, but those who earn more would pay more to the IRS. However, a pure flat tax is not politically viable. As a result, each of the three tax reform proposals involves a modified flat tax, would eliminate some, not all, allowable deductions, and would create several new tax brackets.....Major initiatives under each bill are as follows:

*Bradley-Gephardt would establish three tax brackets with a maximum tax rate of 30% for individuals with income over \$37,500.

*Kemp-Kasten appears to be a flat 25% tax rate but includes a 20% exclusion on wage and salary income up to an adjusted gross income of \$40,000. This effectively creates a 20% marginal tax up to that level. For wage and salary income ranging from over \$40,000 up to an adjusted gross income of \$102,000, the exclusion ranges from 21% to 25%. Only above \$102,000 would a flat 25% marginal rate apply.

*The Treasury bill would establish three tax brackets with a maximum tax rate of 35%.

By increasing exemptions and the zero tax bracket amount, all three proposals would remove at least one million of the lowest income taxpayers from the tax roles. While each bill's recommendations regarding allowable deductions is different, one key difference sets the Treasury and Kemp-Kasten bills apart. Whereas these two bills would retain indexing, adjusting personal income to take inflation's toll into account, the Bradley-Gephardt Bill would not. Moreover, both the Kemp-Kasten and the Treasury bill extend indexing to capital assets. Under the Kemp-Kasten bill, although gains would be fully taxable, they would be indexed, and losses would be fully deductible. Similarly, under the pending Treasury bill, capital gains would be taxed at ordinary rates, but only the amount of a capital gain above inflation

(Financial Check-up cont'd)

would be subject to tax (losses could be used to offset up to \$3000 in income annually).

ANTICIPATED IMPACT.

All three proposals seek to lower the marginal tax rate, which would generally produce an economic incentive. But while most people would welcome reduced rates, revenue losses originating from lower marginal tax rates must be offset by other sources of funds. Under pending proposals, these revenue sources are created by eliminating deductions and subjecting income that is not presently taxed to taxation. This is what's known as broadening the base -- making more income subject to lower tax rates. All three major reform proposals share this goal and seek to raise the same level of taxes from the same class of taxpayers by imposing lower rates.....What does this mean to you? Under each of the major proposals, individual taxpayers could pay more or less in tax, depending on their sources of income and type of deductions. For example, a taxpayer whose income consists primarily of wages and who uses the standard deduction would find his taxes reduced because of the lower rates. Conversely, taxpayers who receive income that presently is not subject to tax, such as income on industrial development bonds or long-term capital gains, will find their tax bills increased. While this may appear to be a negative outlook for investors, there is a bright side. Investors with short-term gains or ordinary dividend and interest income will benefit from lower marginal rates.

THE PROSPECTS FOR CHANGE.

Is it realistic to expect sweeping tax reform in 1985? When evaluating the prospects, there are some important points to bear in mind. Our present tax code has been years in the making, and numerous special interest groups are organized to provide support for various sections of the code. For example, it can be expected that organized charities will fight any reduction in the charitable deduction, since they benefit from high tax brackets and frequently, the cost of charitable giving is borne by the Treasury on a fifty-fifty basis. Or again, state and local governments in high-tax states such as New York will press to block the repeal of allowable deductions for state and local taxes, as proposed under the Treasury bill and the Kemp-Kasten bill..... Overall, it is fair to say that with both parties involved in the issue of tax reform and the President's recommendations soon to be made public, some change will eventually be enacted. But as yet, it's impossible to predict which proposals will be approved, when they will become effective, whether they will apply only to transactions entered into after the law is enacted or whether they will affect investments already made. When planning your investment program, it's important to regard these proposals largely as trial balloons and recognize that it would be premature to base investment decisions on any prospective reform.

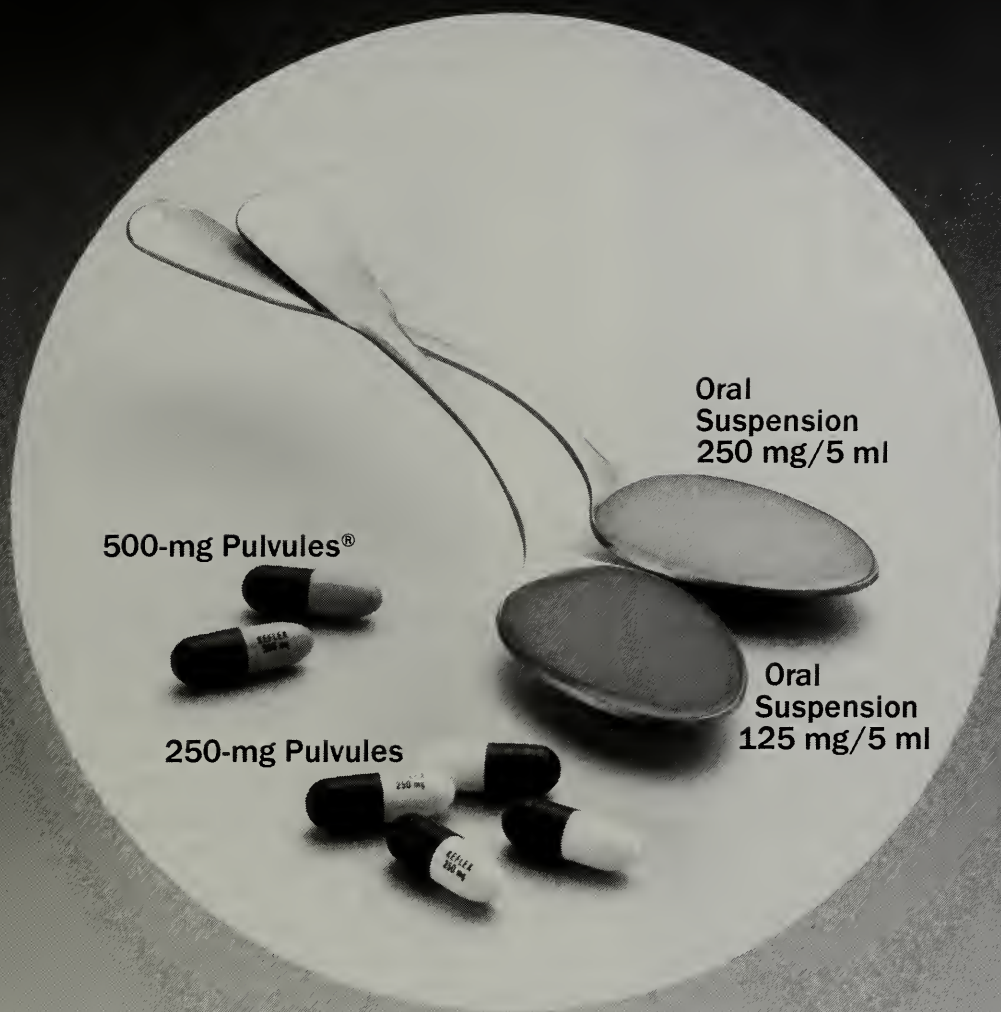
FURTHER INFORMATION

If you would like to receive further information on any of the topics covered in this newsletter, please write to Martin Lefkowitz, CFP, E.F. Hutton & Company, 2700 Middleburg Drive, Suite 200, Columbia, SC 29204; or Call (800) 922-1112.

* * * * *

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ON THE COVER: HOSPITALS DURING THE CONFEDERATE PERIOD IN SOUTH CAROLINA'S MEDICAL HISTORY

With the outbreak of the Confederate War, few hospitals were available to care for South Carolina Confederate victims or other Confederate soldiers who were passing through South Carolina during that difficult time. In many areas of the south, ill or wounded Confederate soldiers were cared for on a makeshift basis. Care was frequently given in private homes, churches, public buildings or temporary structures. The terms, "wayside homes" or "wayside hospitals," came into being during this period when charitable individuals or organizations established centers for the treatment and care of the Confederate soldiers. Initially these wayside homes were not commissioned by the Confederate Medical Department, but later became a major part of Confederate military medicine. The original organization of these wayside homes was frequently left to the direction and management of the women who were left behind.

Numerous relief and aid societies were formed in South Carolina. These organizations provided food, clothing and medicine for South Carolina soldiers and frequently sent these necessities to other states to support the boys from home. The Soldiers' Relief Association was created on July 20, 1861, in Charleston and on July 26, 1861, Columbia residents created the Young Ladies' Hospital Association. There were other associations that provided numerous services such as the Ladies' Clothing Association, the Aid and Relief Association and the Ladies' Christian Association. The support initially was private and later the state began contributing funds. Eventually the control and funding of these organizations were taken over by the Confederate Medical Department.

The frequent movement of troops throughout the state created another need for service which resulted in the formation of the Commissary and Quartermaster Department. Soldiers were frequently without blankets, tents or other necessities

of camp life, and these were provided through commissary sources and through the established wayside hospitals.

In the winter of 1861 it is reported that the soldiers passing through Columbia by rail frequently had to wait for days to obtain care and lodging. This serious need was met by a number of dedicated women's associations who formed modest hospitals and provided for the care of these soldiers. Originally an organization was started at the Charlotte Railroad Depot in Columbia and was later moved to the South Carolina Railroad Department in Columbia, becoming the primary wayside hospital for the area. The Governor's Mansion in Columbia was frequently used as a shelter for soldiers.

Confederate soldiers suffered from many ailments unrelated to actual war-inflicted injuries. For example, in one Charleston wayside hospital during an eight-month period there were over 5,000 diagnoses made on patients. Of this number, there were only 277 gunshot wounds and a scant additional 124 miscellaneous wounds that could be attributed to direct combat. However, there were 143 cases of hepatic disease, 764 of diarrhea/dysentery and 256 cases of typhoid. Rheumatic fever and rheumatism accounted for 363 cases; venereal diseases were about as frequent as gunshot injuries, amounting to 119 of gonorrhea and 139 of syphilis. The most common disease affecting the Confederate soldiers was malaria. Of this same group of individuals, only two patients were reported to have been shell shocked.

In a previous *Journal*, Dr. Devagas' Floating Hospital used in the defense of Charleston harbor was depicted. Shown with this issue is a Union Hospital built at Hilton Head for the care of occupying Federal troops during the Confederate War. The Beaufort Hospital shown below is a converted private home. There was a large Union

field hospital on Morris Island near Charleston harbor which was used during the siege of Charleston.

The quality of care rendered in these wayside hospitals was remarkable for the time. Most physicians had left their homes to travel with the armies, but a few were left behind and with the indispensable help of the Ladies' Aid Societies were able to render care and comfort to the thousands and thousands of injured or ill Confederate soldiers.

— THOMAS M. LELAND, M.D., Ph.D.



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President's Page



LEADERSHIP

Each President, I am certain, approaches his year of service with a certain degree of anxiety about the responsibilities he is assuming. He or she has significant doubts about his literary capability; is he or she knowledgeable about every aspect of the association and will he be able to portray always in a conservative, dignified, sedate manner the great profession he must represent. There will be many times during this year that he will find very little time to spend with his family, and he must learn to cherish those moments carefully and not allow them to slip away into antiquity.

He must always be available, whether it is the media, his peers or his staff who need his assistance. He must have their full cooperation in everything that must be done on behalf of the profession and organized medicine.

The moments he will cherish are perhaps not what one might expect — most of all meeting with his peers and sharing philosophy. He must be able to listen, although there are times when I'm certain no one will believe he has heard.

One prepares oneself as carefully as possible. That preparation should begin in the county medical society, and acceptance of committee assignments, service in the House of Delegates of the SCMA and attendance at reference committee meetings. We need young physicians to be more involved. We need your help; we need your counsel; we need your expertise. You are the leadership of tomorrow. What really is leadership? Most of all it is dedication and willingness to serve.

I urge those who are willing to sacrifice on behalf of the House of Medicine to come forward.

It seems as if it were only yesterday when I was preparing that first editorial for this page, and here I am writing my last editorial. I thank you for the opportunity to have served. I thank everyone for their cooperation and participation. I want particularly to thank the staff — Bill Mahon; Bill Watson; especially do I appreciate Joy Drennen and her tolerance; Donna Murphy for providing that little extra for the Auxiliary; Donna Houston for her prompt consideration to my demands and requests for where I was supposed to go and when; to all the other staff for their attention to the details of making this the sound and effective organization it now is.

My benefit has been in knowing and working with everyone. I believe we now can look forward to the leadership of Leonard Douglas, and I rest assured in his complete capability to assume the Presidency.

God bless you all.

Sincerely, I remain,

A handwritten signature in dark ink, appearing to read 'Ken', with a long, sweeping horizontal line extending to the right.

KENNETH N. OWENS, M.D.
President



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EXECUTIVE VICE PRESIDENT

Mr. William F. Mahon

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INFORMATION FOR AUTHORS

Authors should refer to the detailed instructions in the January issue. Manuscripts and other correspondence
should be addressed: The Editor, JOURNAL OF THE SOUTH CAROLINA MEDICAL ASSOCIATION, Post Office
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All manuscripts should be accompanied by a transmittal letter with the following paragraph: "This original
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published by the SCMA."

We request that manuscripts be concise (no longer than 8 typewritten pages, double-spaced), with no more
than ten references. These should be cited in the text in superscript, e.g., "Bottsford, et al.³", and should conform
to the following style: "3. Bottsford JE, Bearden RC, Bottsford JG: A ten year community hospital experience with
abdominal aorta aneurysms. *J S C Med Assoc* 79: 57-62, 1983." Ordinarily, publication of four small illustrations or
tables or the equivalent will be paid for by *The Journal*. Manuscripts should be submitted in duplicate. Reprints will
be made available by the publisher.



THE JOURNAL

OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

VOLUME 81

APRIL 1985

NUMBER 4

ONE HUNDRED THIRTY-SEVENTH ANNUAL MEETING

THE SHERATON CHARLESTON HOTEL
CHARLESTON, SOUTH CAROLINA
APRIL 24-28, 1985

1985 marks the fifth consecutive year that the Association's Annual Meeting has been held in Charleston. All details, including pre-registration forms, have been sent to the membership, but if additional information is needed, contact SCMA Headquarters at 798-6207. Again this year, there is no registration fee for SCMA members.

The House of Delegates will meet on Thursday, April 25, and again on Sunday, April 28, with Speaker of the House, *Walter J. Roberts, Jr., M.D.*, presiding. Two hundred seven delegates will represent local and county medical societies, specialty societies, Resident Physicians, students, and representatives from DHEC and the two medical schools.

General scientific sessions cover the topics of *Endocrinology* on Friday morning and *Psychiatric Disorders in Primary Care Practice* on Saturday morning. In addition to scientific workshops each afternoon beginning on Wednesday, April 24, there will be a *Symposium on Pulmonary Medicine* on Thursday, and the popular *Sports Medicine Symposium* on Friday. This year's Risk Management Seminar will deal with *Family Stress in Relation to Medical Malpractice Lawsuits*, and a *Mock Deposition* will be presented. AMA Category I credit and AAFP prescribed credit will be awarded on an hour-for-hour basis.

Of special interest is the SOCPAC Luncheon, at which *James J. Kilpatrick*, noted columnist and internationally recognized speaker, will be the special guest. *John J. Coury, M.D.*, Chairman of the AMA Board of Trustees, will brief Delegates on AMA activities during Thursday's House of Delegates meeting.

New this year will be a reception on Thursday

evening, honoring the Delegates and Alternates and our Exhibitors. *Leonard W. Douglas, M.D.*, will be sworn in at the President's Banquet on Saturday evening as the 121st President of the SCMA.

The SCMA Auxiliary will hold its Annual Meeting concurrently with the SCMA meeting and, in addition to the necessary business which must be conducted, many special activities have been planned for Auxiliary members. Again in 1985, Mead Johnson Nutritional Division has organized and will provide the prizes for a golf tournament on Friday afternoon. Several specialty societies will be holding meetings, with both business and scientific sessions scheduled. Alumni activities are numerous. Consult the schedule of events elsewhere in this issue for detailed information.

The SCMA Council meets on Wednesday, April 24 and again at breakfast each day in order to consider business which arises during the House of Delegates meeting.

On-sight registration will be facilitated by personal computers, but members are urged to pre-register if at all possible.

This issue of *The Journal* contains those committee and commission reports, Resolutions, and reports of Officers and Councilors which were available at publication deadline. Additional reports received after this issue has gone to press will be included in the Delegates Handbooks which will be mailed to Delegates prior to the meeting. Delegates are asked to cooperate in passing along their handbooks to an Alternate Delegate if circumstances prevent them from attending.

A summary of Annual Meeting highlights will be published in the SCMA "Newsletter" following the meeting.

— JGD

ONE HUNDRED THIRTY-SEVENTH ANNUAL MEETING

SCHEDULE OF EVENTS Wednesday, April 24, 1985

GENERAL		SCIENTIFIC	
TIME/LOCATION	TOPIC	TIME/LOCATION	TOPIC
7:30-8:30 am Charleston 220	SCMA Council Breakfast	1:00-3:00 pm Defense 216	Scientific Workshop: <i>Office Otolaryngology for Primary Care Practitioners</i> — Warren Y. Adkins M.D. and Staff
8:30 am-12:30 pm Cotillion C	Council Meeting	1:00-3:00 pm Little David 225	Scientific Workshop: <i>Work-up of Upper GI Distress</i> — William H. Marsh M.D. and Staff
12:30-1:30 pm Cotillion B	Council Luncheon	3:30-5:30 pm Little David 225	Scientific Workshop: <i>Diagnosis and Treatment of Common Arrhythmias</i> — Grady H. Hendrix, M.D.
1:30-5:00 pm Cotillion C	Council Meeting	3:30-5:30 pm Prosper 229	Scientific Workshop: <i>Evaluation and Initial Treatment of Trauma Patients in the ER</i> — H. David Reines, M.D.
1:00-5:00 pm Citadel Ballrooms A&B/Peacock Promenade	Exhibitors Setup	3:30-4:30 pm Decatur 209	Meet the Professor: <i>Orthopedic Surgery</i> — John B. McGinty, M.D.
1:00-2:30 pm Auxiliary President's Parlour	Auxiliary Finance Committee Meeting	4:30-5:30 pm Decatur 209	Meet the Professor: <i>Dermatology</i> — Richard L. Dobson, M.D.
1:00-7:00 pm Lobby	SCMA Registration Open		
3:00-4:30 pm Auxiliary President's Parlour	Auxiliary Long Range Planning Committee Meeting		
3:00-5:00 pm Palmetto State 213	Auxiliary Registration		

Thursday, April 25, 1985

GENERAL		SCIENTIFIC	
TIME/LOCATION	TOPIC	TIME/LOCATION	TOPIC
6:30-7:30 am Brittlebank Park	Fun Run Sponsored by MUSC Student Council	2:30-5:30 pm Cotillion B	Symposium: <i>Pulmonary Medicine</i> Moderator: J. Daniel Love, M.D. — <i>Cigarette Smoking: Update '85</i> — Dr. Love
7:00 am-5:00 pm Lobby	SCMA Registration		<i>Upper Airway Obstruction in Clinical Practice</i> — Alfred B. Boykin, M.D.
7:30-8:30 am Charleston 220	SCMA Council Breakfast		<i>Respiratory Therapy in the DRG Era</i> — Dr. Love
7:30-8:30 am Cotillion A	Continental Breakfast Sponsored by MUSC Student Council		<i>Advances in Asthma Diagnosis and Treatment</i> — W. Campbell McLain, M.D.
8:30 am-5:00 pm Palmetto State 213	Auxiliary Registration		

SCHEDULE OF EVENTS

Thursday, April 25, 1985 (continued)

GENERAL		SCIENTIFIC	
TIME/LOCATION	TOPIC	TIME/LOCATION	TOPIC
8:00 am-5:00 pm Citadel Ballroom & Peacock Promenade	Exhibits Open		<i>Respiratory Failure Beyond Blood Gases</i> — Dr. Love
8:30 am-12:00 Noon Cotillions B & C	SCMA House of Delegates	3:00-5:30 pm Charleston 220	Scientific Workshop: <i>Flexible Sigmoidoscopy</i> — Frederick L. Greene, M.D. and Staff Equipment courtesy of Olympus Corp. (max: 50 participants)
9:00-11:00 am Defense 216	Auxiliary Executive Board Meeting	3:30-5:30 pm Hunley 223	Scientific Workshop: <i>Evaluation and Resuscitation of the Newborn</i> — Sami Elhassani, M.D.
11:00 am-12:00 Noon Charleston 220	Auxiliary Brunch	3:30-5:30 pm Little David 225	Scientific Workshop: <i>Hematological Aspects of General Medical Practice</i> — O'Neill Barrett, M.D.
12:30-1:00 pm Auxiliary Presidents' Parlour	Auxiliary Past Presidents' Dessert	3:30-5:30 pm Defense 216	Scientific Workshop: <i>Obstetrics and Gynecology: Invitro Fertilization</i> — Charles C. Tsai, M.D. <i>Laser In Gynecological Procedures</i> — Gary Eddy, M.D.
12:15-2:00 pm Cotillion A	MUSC Alumni Annual Luncheon Meeting		
12:30-1:30 pm Decatur 209	Reference Committee Chairmen's Luncheon		
1:30-3:00 pm Rooms 216, 223, 225, 220	SCMA Reference Committee Meetings		
3:00-4:30 pm Rooms 229, 209, and Cotillion C	SCMA Reference Committee Meetings		
6:00-7:30 pm Cotillion A	Reception Honoring Delegates, Alternates and Exhibitors Sponsored by S. C. Medical Bldg. Corp. and S. C. Medical Care Foundation		
7:30-10:30 pm Wickliffe House The Colony House	MUSC Alumni Reunions Class of 1945 Class of 1955		

Friday, April 26, 1985

GENERAL		SCIENTIFIC	
TIME/LOCATION	TOPIC	TIME/LOCATION	TOPIC
7:00 am-5:00 pm Lobby	SCMA Registration Open	8:00 am-4:00 pm Palmetto State 213	S. C. Dermatological Association Meeting (Includes Scientific Session)
7:30-8:30 am Charleston 220	SCMA Council Breakfast	8:00 am-12:30 pm Cotillion C	General Scientific Session <i>Update in Endocrinology</i> Moderator: Kay F. McFarland, M.D. — <i>Thyroid Function in Thyroid and Non-thyroid Illness</i> — Robert D. Utiger, M.D.
8:00 am-5:00 pm Citadel Ballrooms and Peacock Promenade	Exhibits Open		
8:30-9:30 am Cotillion A	Auxiliary Breakfast		

SCHEDULE OF EVENTS

Friday, April 26, 1985 (continued)

GENERAL		SCIENTIFIC	
TIME/LOCATION	TOPIC	TIME/LOCATION	TOPIC
9:00-10:30 am Defense 216	Professional Liability Committee		<i>A New Look at Amenorrhea</i> — Dr. McFarland
9:00 am-11:00 am Prosper 229	South Carolina Medical Care Foundation General Membership Meeting followed by Board of Directors Meeting		<i>Hypoglycemia: When Is It Real?</i> — Jon H. Levine, M.D.
9:30 am-12:30 pm Cotillion B	Auxiliary House of Delegates		<i>Hypercalcemia: Work-up & Therapy</i> — Dr. Utiger
10:30 -11:30 am Defense 216	SCIMER Board		<i>Sexual Function in Aging Men</i> — Howard Nankin, M.D.
12:30 pm Patriot's Point	Golf Tournament — Organized by and Prizes Awarded by Mead Johnson Nutritional Division	1:30-5:00 pm Cotillion C	Symposium: <i>Sports Medicine</i> Moderator: Roland M. Knight, M.D.
12:00 Noon-1:30 pm Defense 216	Editorial Board Luncheon		<i>Facial Injuries</i> — Robert A. Wilson, M.D.
12:00 Noon-1:30 pm Prosper 229	Sports Medicine Committee Luncheon Meeting		<i>Dermatological Problems with Athletes</i> — Kenneth W. Smith, M.D.
12:30-2:00 pm Cotillion A	Auxiliary Luncheon		<i>Trainers, Physicians and Coaches — The Role of Each</i> — Coach Cally Gault, Former Coach and present Athletic Director of Presbyterian College
12:30-2:00 pm Decatur 209	Ophthalmology Society Executive Committee Luncheon Meeting		<i>Guidelines for Returning the Athlete to Participation</i> — Frederick E. Reed, M.D.
2:00-4:00 pm Cotillion B	Auxiliary Political Seminar		<i>Demonstration and Discussion: Taping, Braces, Equipment and Heat Station</i> — Fred Hoover, Trainer, Clemson University
4:00-5:30 pm Cotillion A	Auxiliary Wine Testing		
4:30-5:30 pm Decatur 209	SCMA Committee on Aging	1:30-5:00 pm Charleston 220	Symposium: <i>S. C. Diabetes Association</i>
5:30-6:30 pm Decatur 209	S. C. Academy of Family Physicians Committee on Aging	2:30-4:30 pm Defense 216	Symposium: <i>S. C. Oncology Society</i>
6:30-7:30 pm Cotillion C	Reception Sponsored by Geer Health Services, Division of Geer Drug Company	2:30-4:30 pm Hunley 223	Scientific Workshop: <i>Outpatient Infection Problems</i> — Charles S. Bryan, M.D.
5:00-7:00 pm Palmetto State 213	Duke Alumni Reception		
7:30-10:30 pm Lodge Alley Inn	MUSC Alumni Reunions	2:30-4:30 pm Little David 225	Scientific Workshop: <i>How to Make the Best of Radiological Imaging!</i> — John H. Stanley, M.D., Stephen I. Schabel, M.D. and Paul Ross, M.D.
The Colony House	Class of 1940		
Sheraton, Cotillion A	Class of 1950		
Lodge Alley Inn	Class of 1960		
Sheraton, Cotillion B	Class of 1965		
	Class of 1975		

SCHEDULE OF EVENTS

Friday, April 26, 1985 (continued)

GENERAL		SCIENTIFIC	
TIME/LOCATION	TOPIC	TIME/LOCATION	TOPIC
		2:30-4:30 pm Prosper 229	Scientific Workshop: <i>When to Get a Genetics Evaluation</i> — Roger E. Stevenson, M.D.

Saturday, April 27, 1985

GENERAL		SCIENTIFIC	
TIME/LOCATION	TOPIC	TIME/LOCATION	TOPIC
7:00 am-5:00 pm Lobby	SCMA Registration Open	8:00-11:00 am Cotillion B	S. C. Chapter American Academy of Pediatrics and S. C. Pediatric Society Meeting and Scientific Session
7:30-8:30 am Charleston 220	SCMA Council Breakfast	8:30 am-12:30 pm Cotillion C	General Scientific Session <i>Psychiatric Disorders in Primary Care Practice</i> Moderator: R. Ramsey Mellette, M.D.
8:00 am-12:30 pm Citadel Ballrooms & Peacock Promenade	Exhibits Open	9:30 am-12:30 pm Charleston 220	<i>Panic Anxiety and Its Treatment</i> — James C. Ballenger, M.D.
8:00 am-4:00 pm Palmetto State 213	S. C. Dermatological Association Meeting		<i>The Newer Anti-depressants</i> — Charles Kellner, M.D.
8:00-11:00 am Hunley 223	S. C. Society of Neurological Surgeons Meeting		<i>Sleep and Aging</i> — Dr. Ballenger
8:00 am-5:00 pm Defense 216	S. C. Society of Pathologists Meeting		<i>Anorexia Nervosa and Bulimia</i> — Richard K. Harding, M.D.
9:00-11:00 am Prosper 229	SOC PAC Board Meeting	2:30-5:00 pm Cotillions B & C	S. C. Radiological Society Scientific Session
11:00 am-12:30 pm Decatur 209	Business Meeting S. C. Chapter American Academy of Pediatrics and S. C. Pediatric Society		Risk Management Seminar <i>Family Stress in Relation to Medical Malpractice Lawsuits</i> <i>Mock Deposition</i>
12:30-1:30 pm Prosper 229	S. C. Radiological Society Reception		
1:30 am-3:30 pm Charleston 220	S. C. Radiological Society Luncheon and Meeting		
12:30-3:00 pm Little David 225	S. C. Chapter American Academy of Pediatrics and S. C. Pediatric Society Executive Comm. Luncheon		
12:45-2:15 pm Cotillion A & B	SOC PAC Luncheon Speaker: James J. Kilpatrick		
1:00-2:30 pm Hunley 223	House Staff Physicians Meeting		
2:00-6:00 pm Decatur 209	S. C. Psychiatric Association General Membership Meeting		

SCHEDULE OF EVENTS

Saturday, April 27, 1985 (continued)

<i>GENERAL</i>	
TIME/LOCATION	TOPIC
3:00-6:00 pm Prosper 229	S. C. Academy of Family Physicians Board of Directors Meeting
6:30-7:30 pm Citadel A & B	SCMA Presidents' Reception
7:30 pm-12:00 am Cotillions A, B, & C	SCMA Banquet

Sunday, April 28, 1985

<i>GENERAL</i>	
TIME/LOCATION	TOPIC
7:00-10:30 am Lobby	SCMA Registration Open
7:30-8:30 am Charleston 220	SCMA Council Breakfast
7:30-8:30 am Citadel Ballroom A	SCMA Past Presidents' Breakfast
8:30-12:30 pm Cotillions A & B	SCMA House of Delegates
12:30 pm Cotillions A & B	Council Reorganization

1985 DELEGATES AND ALTERNATES

ABBEVILLE	Not available		C. Guy Castles, Jr., M.D.
AIKEN	Charles H. Hewitt, Jr., M.D.		Eloise A. Bradham, M.D.
	William L. Meehan, M.D.		C. Warren Irvin, M.D.
	Clarence Flanigan, Jr., M.D.		William C. Cantey, M.D.
ALLENDALE	Thomas B. Warren, Jr., M.D.		Edward E. Kimbrough, III, M.D.
Alternate:	Wilbur R. Tuten, Jr., M.D.		Robert Stafford, M.D.
ANDERSON	Jerry R. Powell, M.D.		Ronald Collins, M.D.
	Kenneth W. Smith, M.D.		Walter J. Roberts, Jr., M.D.
	Edward C. Mattison, M.D.		Joseph W. Taber, Jr., M.D.
	Newman W. Harter, M.D.		John M. Preston, M.D.
	Vernon E. Merchant, M.D.		Roslyn D. Taylor, M.D.
	Charles W. Hinnant, M.D.		Edward W. Catalano, M.D.
	DeWitt C. Niles, M.D.		Alexander G. Donald, M.D.
Alternates:	John B. Martin, M.D.		James W. Stands, M.D.
	J. David Clyde, M.D.		Caroline Gibbs, M.D.
	C. Don Bryant, M.D.		William Crosswell, M.D.
BAMBERG	F. Marion Dwight, M.D.		Stacey Ann V. Brennan, M.D.
Alternate:	Herbert A. Moskow, M.D.	Alternates:	Connie O. Mellette, M.D.
BARNWELL	William B. Clark, M.D.		A. McKay Brabham, M.D.
Alternate:	Mir O. Khan, M.D.		Warren F. Holland, M.D.
BEAUFORT	Not available		Alden Sweatman, M.D.
BERKELEY	Not available		Thomas C. Rowland, Jr., M.D.
CHARLESTON	Bartolo M. Barone, M.D.	DARLINGTON	W. Rion Dixon, M.D.
	Walter M. Bonner, Jr., M.D.		Morrison Farish, M.D.
	Fletcher C. Derrick, Jr., M.D.	DILLON	Rufus H. Cain, M.D.
	William B. Thomason, M.D.	Alternate:	Swift C. Black, M.D.
	Ralph F. Principe, M.D.	DORCHESTER	Not available
	John C. Hawk, Jr., M.D.	EDISTO	W. L. Davis, M.D.
	Grant W. Patton, Jr., M.D.		J. F. Johnson, Jr., M.D.
	James L. Purcell, M.D.	Alternates:	J. L. Wells, M.D.
	Daniel Ravenel, M.D.		B. C. Pendarvis, Jr., M.D.
	Dowse D. Rustin, M.D.		D. W. Lovelace, III, M.D.
	Richard E. Ulmer, M.D.	FAIRFIELD	Roger A. Gaddy, M.D.
	David D. Egleston, M.D.	Alternate:	Harmon F. Patrick, M.D.
	George G. Durst, Jr., M.D.	FLORENCE	Marion Carr, Jr., M.D.
	Clay W. Evatt, Jr., M.D.		William H. Hester, M.D.
	John C. Hawk, III, M.D.		Bruce W. White, Jr., M.D.
	Louie B. Jenkins, M.D.		Stephen A. Imbeau, M.D.
	Samuel E. Hazell, M.D.		Phillip H. Greenberg, M.D.
	Margaret M. Metcalf, M.D.		George R. Dawson, III, M.D.
	Albert F. Aiken, M.D.	Alternates:	Larry D. Rabon, M.D.
	W. L. Ector, M.D.		Steven R. Ross, M.D.
	H. Biemann Othersen, Jr., M.D.	GEORGETOWN	Richard M. Camlin, M.D.
Alternates:	George DelPorto, M.D.		George A. Sowell, M.D.
	Thomas B. Harper, III, M.D.	Alternates:	J. Foote Hooper, IV, M.D.
	William B. Gamble, III, M.D.		Timothy D. Youell, M.D.
	Thomas M. Leland, M.D.	GREENVILLE	Daggett O. Royals, M.D.
	Don A. Schweiger, M.D.		Lewis N. Terry, M.D.
	Leon Banov, Jr., M.D.		George M. Grimbail, M.D.
CHEROKEE	Rudolph R. Steuer, Jr., M.D.		Donald G. Kilgore, Jr., M.D.
Alternate:	John H. Cathcart, Jr., M.D.		Robert E. Robards, M.D.
CHESTER	M. L. Marion, Jr., M.D.		William R. Craig, III, M.D.
Alternate:	Richard P. Hughes, M.D.		Woodrow W. Long, Jr., M.D.
CHESTERFIELD	William L. Perry, M.D.		Thomas C. Mann, M.D.
Alternate:	Winston Y. Godwin, M.D.		Chester A. Noble, M.D.
COLLETON	John B. Johnston, M.D.		S. R. Littlepage, M.D.
Alternate:	Rexford H. Hunt, M.D.		Ted J. Roper, M.D.
COLUMBIA	Herbert B. Niestat, M.D.		Ronald L. Ashton, M.D.
	Robert N. Milling, M.D.		J. Duncan Burnette, Jr., M.D.
	Albert L. Reid, M.D.		Lawrence N. Bellew, M.D.
	James C. Vardell, Jr., M.D.		Wayne C. Brady, M.D.

1985 DELEGATES AND ALTERNATES

Alternates: William W. Pryor, M.D.
W. J. Bannen, Jr., M.D.
Jennings G. Pressly, M.D.
Steven J. Gold, M.D.
Robert L. Chironna, M.D.
Jefferys A. Macfie, M.D.
K. Dan Adcock, M.D.
Richard B. Dreskin, M.D.
Russell G. Gaddy, M.D.
Lucius M. Cline, Jr., M.D.
GREENWOOD Richard M. Carter, M.D.
Oliver T. Willard, M.D.
Frank W. Shealy, M.D.
HAMPTON Count Pulaski, Jr., M.D.
Alternate: James B. Causey, M.D.
HORRY James N. Craigie, M.D.
Thomas A. Whitaker, M.D.
James M. Lindsey, Jr., M.D.
G. Phillip Hillen, M.D.
Joe N. Jarrett, Jr., M.D.
JASPER J. M. Bennett, Jr., M.D.
Alternate: John O. Ryan, M.D.
KERSHAW Lawson W. Lewis, M.D.
Alternate: Lawrence H. Parrott, M.D.
LANCASTER Not available
LAURENS Not available
LEXINGTON F. L. Clark, M.D.
Charles F. Crews, M.D.
Frank W. Young, M.D.
Alternate: James L. Hahn, M.D.
MARION James R. Carroll, M.D.
Ira Barth, M.D.
Alternates: James S. Garner, M.D.
Elliott Finger, M.D.
MARLBORO James C. McAlpine, M.D.
Alternate: William C. Whitner, M.D.
NEWBERRY Robert E. Livingston, III, M.D.
Alternate: Carroll A. Pinner, III, M.D.
OCONEE Edward H. Booker, M.D.
Joseph B. James, M.D.
Alternate: Julius R. Earle, M.D.
PICKENS William E. Marks, Jr., M.D.
Allen J. Thompson, Jr., M.D.
Alternates: W. Carl Walsh, Jr., M.D.
Larry R. Winn, M.D.
RIDGE James S. Garrison, M.D.
Alternate: Richard A. Steadman, M.D.
SPARTANBURG Thomas L. Robinson, M.D.
Ronald R. Terrell, M.D.
Lucien E. Brailsford, M.D.
James J. Jakubchak, M.D.
Darwin W. Keller, M.D.
Jerry A. Majure, M.D.
Milton D. Sarlin, M.D.
Gaines W. Hammond, Jr., M.D.
James E. Brown, M.D.
James D. Bearden, III, M.D.
H. Albert Stresing, M.D.
Carol S. Nichols, M.D.
Alternates: Eric C. Nelson, M.D.
Melvin D. Medlock, M.D.
Frederick F. Adams, III, M.D.

SUMTER James O. Johnson, M.D.
Charles H. White, Jr., M.D.
E. MacDonald DuBose, M.D.
J. Capers Hiott, M.D.
Allen P. Bruner, M.D.
UNION W. Standord James, M.D.
WILLIAMSBURG H. H. Poston, Jr., M.D.
Alternate: John R. Egbert, M.D.
YORK E. Earl Jenkins, Jr., M.D.
Robert Wilson, Jr., M.D.
W. Gaines Entrekinn, M.D.
David O. Holman, Jr., M.D.
Robert D. Randall, Jr., M.D.
Alternates: Donald W. Shuler, M.D.
W. E. Gregory, Jr., M.D.
Dennis M. Gettelfinger, M.D.
Terry L. Dodge, M.D.

S. C. SOCIETY FOR ALLERGY & CLINICAL IMMUNOLOGY

Not available

S. C. SOCIETY OF ANESTHESIOLOGISTS

John E. Mahaffey, M.D.

Alternate: Laurie L. Brown, M.D.

S. C. CARDIAC & THORACIC SURGICAL SOCIETY

Robert M. Sade, M.D.

Alternate: James E. May, M.D.

S. C. DERMATOLOGICAL ASSOCIATION

Linwood G. Bradford, M.D.

S. C. CHAPTER, AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

Not available

S. C. ACADEMY OF FAMILY PHYSICIANS

William D. Brearley, M.D.

Alternate: Spencer C. Disher, Jr., M.D.

S. C. INTERNAL MEDICINE SOCIETY

John B. Dubose, M.D.

Alternate: George E. Malanos, M.D.

S. C. ASSOCIATION OF NEUROLOGICAL SURGEONS

Not available

S. C. NEUROLOGICAL ASSOCIATION

Edward L. Hogan, M.D.

S. C. OB/GYN SOCIETY

Frank J. Wyman, M.D.

Alternate: John F. Hooker, Jr., M.D.

S. C. SOCIETY OF OPHTHALMOLOGY

Thomas M. Leland, M.D.

S. C. ORTHOPEDIC ASSOCIATION

Julian L. Mason, Jr., M.D.

Alternate: William B. Evins, M.D.

S. C. SOCIETY OF OTOLARYNGOLOGY

Warren Y. Adkins, M.D.

Alternate: Benjamin White, M.D.

S. C. SOCIETY OF PATHOLOGISTS

F. Stewart Clare, M.D.

Alternate: James L. Maynard, M.D.

S. C. CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICIANS and the S. C. PEDIATRIC SOCIETY

John W. Rheney, Jr., M.D.

Alternate: C. Warren Derrick, M.D.

1985 DELEGATES AND ALTERNATES

S. C. SOCIETY OF PLASTIC & RECONSTRUCTIVE SURGEONS

Not available

S. C. PSYCHIATRIC ASSOCIATION

Thomas W. Messervy, M.D.

Alternate: J. Michael Foxworth, M.D.

S. C. RADIOLOGY SOCIETY

Harold W. Sanford, Jr., M.D.

S. C. CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS

Not available.

S. C. SURGICAL SOCIETY

William M. Rambo, M.D.

S. C. UROLOGICAL ASSOCIATION

Not available.

S. C. VASCULAR SURGICAL SOCIETY

R. Neal Reynolds, M.D.

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Daniel E. Mikell, M.D.

Bonnie J. Ramsey, M.D.

Alternate: Leonard W. Douglas, Jr., M.D.

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W. Marcus Newberry, M.D.

UNIVERSITY OF SOUTH CAROLINA, DEAN, SCHOOL OF MEDICINE

J. O'Neal Humphries, M.D.

MUSC SENIOR CLASS PRESIDENT (COLLEGE OF MEDICINE)

Michael P. Russell, Ph.D.

USC SENIOR CLASS PRESIDENT (SCHOOL OF MEDICINE)

Ruben Mayer

PARLIAMENTARIAN

James Long, M.D.

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Walter J. Roberts, Jr., M.D.

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O. Marion Burton, M.D.

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J. Ernest Lathem, M.D.

AMA DELEGATES AND ALTERNATE DELEGATES

C. Tucker Weston, M.D.

Waitus O. Tanner, M.D.

John C. Hawk, Jr., M.D.

Alternates:

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Leonard W. Douglas, M.D.

Euta M. Colvin, M.D.

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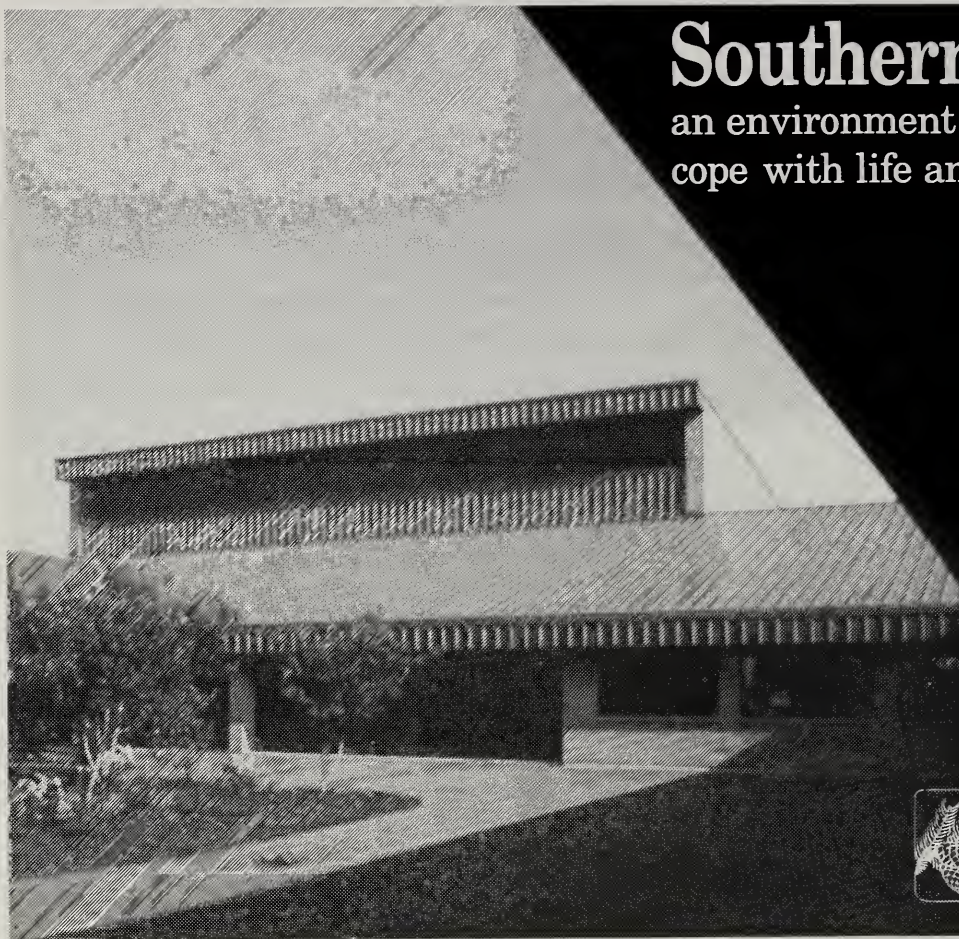
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William H. Hester, M.D., Councilor, Sixth District

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SCMA

NEWSLETTER

April, 1985

LAST MINUTE NEWS: 1985 ANNUAL MEETING - APRIL 24-28, CHARLESTON, S. C.

As this "Newsletter" goes to press, there are approximately 200 pre-registrants for the 137th Annual Meeting of the South Carolina Medical Association at the Sheraton Charleston, April 24 through 28.

We call your attention to several important matters concerning the meeting, as follows:

DELEGATES' HANDBOOKS: As instructed by the House of Delegates in 1984, Delegates' Handbooks will be mailed prior to the meeting. The mailing is scheduled for the week of April 8. *Duplicate handbooks will not be available in Charleston for all Delegates. If a Delegate finds he cannot attend the meeting for any reason, he should pass his handbook along to a designated Alternate Delegate from his county society.*

RESOLUTIONS RECEIVED TO DATE: As of this writing, the following Resolutions have been received and referred to appropriate Reference Committees:

"Restructuring the Medicare Law," submitted by the S. C. Chapter, American Academy of Family Physicians

"Sexual Abuse of S. C. Children," submitted by the Columbia Medical Society

"Head Gear Requirement for Horse Sports," submitted by the Columbia Medical Society

"Unnecessary Diagnostic Studies and/or Treatment," submitted by the Columbia Medical Society

"Dumping of Toxic Waste in South Carolina," submitted by Sumter-Clarendon Medical Society

NEW PROCEDURE FOR HOLDING ANNUAL ELECTIONS: A new procedure will be used this year in conducting the annual elections of officers and other elected officials. Nominations will be accepted during the House of Delegates session on Thursday, April 25. Ballots for contested positions will be distributed to voting Delegates at the Credentials desk on Sunday morning, collected and counted. The results will be announced prior to the closing of the Sunday morning session.

SOCPAC LUNCHEON: Members are reminded that tickets for the SOCPAC Luncheon on Saturday, April 27, are limited, although additional space has been provided since the last announcement. *Mr. James J. Kilpatrick, noted columnist and lecturer will be the guest speaker. First preference for tickets will be given to SOCPAC members.*

CHANGES IN MIT WELL-RECEIVED

The Board of Trustees of the SCMA Members' Insurance Trust is pleased to announce that the transition period for claims administration has progressed smoothly. The change from Blue Cross and Blue Shield to Provident Life has been well-received by the membership, as has the new age-banded premium structure. The Board anticipates an increase in enrollment as a result of these positive changes, and expresses appreciation to the members for their support during the changeover.

For information about health insurance under the Trust for you, your family and your employees, call the Insurance Manager, Mary Ann West, at 798-6207.

APPOINTMENTS TO MEDICAL DISCIPLINARY COMMISSION

Council has nominated the following physicians for reappointment to the Medical Disciplinary Commission of the State Board of Medical Examiners:

<i>First District:</i>	<i>Thomas G. Herbert, Jr., M. D.</i>
<i>Second District:</i>	<i>Boyce M. Lawton, Jr., M. D.</i>
<i>Third District:</i>	<i>Charles T. Battle, M. D.</i>
<i>Fourth District:</i>	<i>W. Wallace Fridy, Jr., M. D.</i>
<i>Fifth District:</i>	<i>Robert E. Lee, M. D.</i>
<i>Sixth District:</i>	<i>Emmet W. Flynn, Jr., M. D.</i>

In notifying the SCMA of the expiration of the current terms of these members, the State Board of Medical Examiners advised that "all of the ... members have served faithfully and we offer their names for renomination."

CONFERENCE ON THE PREVENTION OF CHILD ABUSE AND NEGLECT

The SCMA Council recently approved plans for a statewide conference on the prevention of child abuse and neglect. SCMA has endorsed and will fund this project, initiated by the SCMA Auxiliary.

The Conference will be held in Columbia at the Carolina Inn on Thursday, October 3, 1985. The "Action for Child Protection" group from Aurora, Colorado will provide the program materials and the speaker, *Dr. Robert W. ten Bensel*. Dr. ten Bensel is a Professor in the School of Public Health, Department of Pediatrics, and Adjunct Professor at the Center for Youth Development and Research. He is also the Director of the Program in Maternal and Child Health in the School of Public Health at the University of Minnesota. His primary interests are in the area of prevention and health promotion for children and their families, with a special interest in prevention of child abuse and neglect. He is among the most notable lecturers on child maltreatment nationally and is always in great demand.

The conference will be directed primarily towards physicians and spouses, physicians' office personnel and key individuals active in the child protection field throughout the state. CME credit will be provided. The Auxiliary will handle publicity and The Journal will carry a registration form and other pertinent information on the Auxiliary Page. Watch for more information as plans are finalized.

AMA PRESIDENT HAS WHIRLWIND TOUR IN SOUTH CAROLINA

Joseph F. Boyle, M.D., President of the American Medical Association, visited South Carolina on March 18 and 19, 1985. Dr. Boyle was an honored guest at the 1984 Annual Meeting of the South Carolina Medical Association.

During his visit, Dr. Boyle attended rounds with residents in the USC School of Medicine at Richland Memorial Hospital and addressed medical students later in the day at the Sumter Highway campus. He appeared on a mid-day television talk show in Columbia and later taped a television interview shown statewide on the educational television network.

His visit also included discussions with the editorial staff of Columbia newspapers, and an interview with Orangeburg newspaper reporters. He addressed the Greater Columbia Area Chamber of Commerce, as well as a joint meeting of the Orangeburg Rotary and Kiwanis clubs.

Dr. Boyle spoke to the Columbia Medical Society at a special called meeting on the subject of "If We Don't Care, Who Does?" He had an especially meaningful discussion with Governor Richard W. Riley who expressed keen interest in the Health Policy Agenda for the American People, an AMA project of which Dr. Boyle is Chairman. An opportunity to talk with members of the South Carolina General Assembly presented itself as he attended the SCMA Legislative Reception.

The South Carolina Medical Association was honored to have Dr. Boyle visit our state. Of interest also is the fact that several other key AMA officers have or will be visiting South Carolina during April and May. *John J. Coury, Jr., M. D., Chairman of the AMA Board of Trustees, will attend the SCMA Annual Meeting this month. President-Elect Harrison Rogers, M. D., addressed the Alpha Omega Alpha medical society at its annual initiation banquet on April 4 in Charleston; and James E. Davis, M. D., Speaker of the AMA House of Delegates, will address the American Academy of Medical Directors at its Annual Meeting and National Conference on May 15 at the Marriott on Hilton Head Island.*

KILGORE TO RECEIVE PHYSICIAN'S AWARD FOR COMMUNITY SERVICE

At the Council meeting on March 20, Donald Gibson Kilgore, Jr., M. D., Greenville, was voted recipient of the A. H. Robins' Physician's Award for Community Service. The award will be presented during the Inauguration Banquet on Saturday, April 27, at the SCMA Annual Meeting.

In nominating Dr. Kilgore for this award, Daggett O. Royals, M. D., President of the Greenville County Medical Society stated, "Dr. Kilgore's active participation and service to our Society, to the South Carolina Medical Association, and to the American Medical Association is reflective of his dedication to organized medicine. He is an outstanding member of our community, participating in various civic, social and charitable organizations. His concern for the well-being of the children of Greenville County is evident in his service as a Trustee of the School District of Greenville County, an office he has held since 1970."

Congratulations are in order to those physicians also nominated who are held in such high esteem in their communities: *Harold P. Hope, M. D., T. James Bell, Jr., M. D., Charles F. Crews, M. D., W. Wyman King, M. D., Frank P. Gaston, M. D., Stoney A. Abercrombie, M. D., George Poda, M. D., and Harold G. Morse, M. D.*

COLORECTAL CANCER EDUCATION WEEK

The American Cancer Society has designated April 15-20, 1985 as Colorectal Cancer Education Week, as part of a nationwide effort to reduce America's death toll from this disease.

Colorectal cancer, the second leading cause of cancer deaths in this country, will strike approximately 134,000 Americans, including 1200 South Carolina residents. Approximately 60,000 adults will die from the disease, including 550 South Carolinians.

Colorectal cancer is a very curable disease if detected early. The purpose of this special week is to make the public and medical profession more aware of the measures that can be taken to protect against colorectal cancer. A national survey by the American Cancer Society showed that most people don't realize that examinations for colorectal cancer should be part of a regular physical examination, and that the disease can be detected long before symptoms appear. With early detection, the cure rate could rise from the present 44% to as high as 75%.

During the week, ACS will attempt to reach as many adults over 50 as possible, since risk for the disease increases with age. The importance of digital rectal examination, stool blood tests and proctosigmoidoscopy will be emphasized. The South Carolina Division of the American Cancer Society sponsored a free course for physicians on colorectal cancer and flexible sigmoidoscopy in Columbia in January. Another course is planned for Charleston in October.

Contact the local unit of the American Cancer Society for further information on educational materials which may be helpful for you and your patients.

CAPSULES....

....Honorary membership status has been awarded to: *James C. Belk, M. D., Anderson; William J. Nelson, M. D., Spartanburg; Lloyd W. Luttrell, M. D., Spartanburg; Frances L. Timmons, M. D., Columbia; and Kemper D. Lake, M. D., Whitmire....*

.....The SCMA Council has requested the Governor to re-appoint *Jack A. Evans, Jr., M. D., C. Tucker Weston, M. D., and Donald G. Kilgore, Jr., M. D.,* to the Board of Directors of the Patients' Compensation Fund.

DID YOU KNOW....

that members of the South Carolina Medical Association pay less for membership than members of 40 other state medical associations? ... that the SCMA has not had a dues increase in more than eight years?

For physicians who participate in all three areas of organized medicine -- the AMA, state and county societies -- Linn County, Iowa has the highest combined dues schedule in the country, \$1,205. Southwestern County Medical Society in Virginia has the lowest combined dues rate, \$495.00.

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ELECTIONS: 1985

The following elections will take place upon approval of the new Constitution, which eliminates the positions of First and Second Vice Presidents and creates a Board of Trustees.

OFFICERS: President-Elect:

Secretary: Elected annually, limited to three consecutive terms. J. Gavin Appleby, M.D., elected 1983. Re-elected 1984. Eligible for one additional term.

Treasurer: Nominated by Council. Elected annually, limited to three consecutive terms. Thomas C. Rowland, Jr., M.D., elected 1984. Eligible for two additional terms.

MEDICAL DISTRICT TRUSTEES:

District 1: Limited to three Consecutive two-year terms. Bartolo M. Barone, M.D. Elected 1978. Re-elected 1979 (Odd-Even Requirement). Re-elected 1981, 1983. Not eligible for re-election in 1985.

J. Frank Biggers, III, M.D. Elected 1978. Re-elected 1979 (Odd-Even Requirement). Re-elected 1981, 1983. Not eligible for re-election in 1985.

District 3: E. Mims Mobley, Jr., M.D. Elected 1977. Re-elected 1979 (Odd-Even Requirement). Re-elected 1981, 1983. Not eligible for re-election in 1985.

District 5: William M. Hull, Jr., M.D. Elected 1979. Re-elected 1981 and 1983. Not eligible for re-election in 1985.

District 7: S. Perry Davis, M.D. Elected 1983. Eligible for two additional terms.

District 9: J. Sidney Fulmer, M.D. Elected 1981. Re-elected 1983. Eligible for one additional term.

AMA DELEGATE:

C. Tucker Weston, M.D., term expires 12/31/85.

AMA ALTERNATE DELEGATE:

Randolph D. Smoak, Jr., M.D., term expires 12/31/85

SPEAKER OF THE HOUSE:

Limited to three consecutive two-year terms. Walter J. Roberts, Jr., M.D., filling unexpired term of Hugh Wells, M.D., who was elected in 1983. Eligible for re-election.

VICE SPEAKER OF THE HOUSE:

Limited to three consecutive two-year terms. O. Marion Burton, M.D., filling unexpired term of Walter J. Roberts, Jr., M.D., who was elected in 1983. Eligible for re-election.

STATE BOARD OF MEDICAL EXAMINERS:

District 1: C. William Wimberly, Jr., M.D.

District 3: Vernon E. Merchant, Jr., M.D.

REPORT OF THE PRESIDENT

This report to the 1985 House of Delegates will address where we have been during this year and what we may have accomplished. The painful process of the termination of an Executive Vice President and employment of our new Executive Vice President is over, and we have effectively consolidated the staff under Mr. William Mahon's leadership. We have sold a property and purchased a new building with a new location and a new image — everyone under one roof. All corporations are now consolidated into the South Carolina Medical Association, Inc.

There has been considerable activity for the Association in helping to educate the membership in the area of HMO development. A statement about this was developed by the Task Force on Alternate Delivery Systems, and this document was refined by Council. I believe we have fulfilled our responsibility offering any information we had plus the very capable administrative expertise of our Executive Vice President.

If the proposed Indigent Care Bill should pass in any form resembling the present one, I believe the Association should offer the Health and Human Services Finance Commission every assistance possible to accomplish a pilot program in HMO development, the most logical being the Physicians Health Care Plan of Columbia/Lexington County if that is the intent of the HHS Finance Commission.

I believe we have throughout the state begun to openly talk with the business coalitions and some of the plaintiff bar about the professional liability problem. We have prepared six pieces of tort reform legislation which are at this time being rewritten. I also believe we *have not developed* a public relations program in the area of professional liability and tort reform. We should employ the best public relations consultant possible to develop a package to submit to the media — print, radio, TV — at the very latest *by September, 1985* which would *educate the public* of the complexities of the medical professional liability problem — not the problem outside of South Carolina but the problems which exist within this state. I realize that the cost may be great but failure to do this may make the cost even greater.

There have been changes made in our Insurance Trust which I believe are the most sound moves we have made since the Trust was formed. I would like to see these changes solidified and

look forward to a further improvement in the benefit package in the future, as accumulation of reserves indicates.

The legislative program under the direct supervision of the President-Elect allows more thorough evaluation of issues and more prompt responses when information is needed. The recent change in our lobbyist will result in allowing the President and others to properly prepare for testimony days or weeks in advance so that he or she can be fully oriented about every subject before he or she is called to testify. The same should pertain to any other leader, regardless of his or her position, when called upon to offer their expertise.

For some reason, there is and has been more interest in the INTRAV trips; perhaps under Bill Watson's tutelage the programs are more attractive and the membership is more responsive, therefore better able to participate in the very fine adventures. Examine each one carefully. We now have a master planner putting these delightful experiences together.

We have just completed our first leadership conference for South Carolina, and I know this was a great success — not only from the interest shown by the leaders of the various societies, but the very complete participation of Auxiliary leaders, and the sincerity and dedication of the faculty. We can certainly look forward to expanding and continuing this program each year.

We need to more adequately cooperate with our Auxiliaries. These ladies and a few males are in every organized auxiliary providing needed supplementary services in many areas directly or indirectly related to health care. I would suggest that there should be more interaction between organized medicine and this very energetic, cooperative, and useful arm. The arm is there — waiting, willing, and fully capable of accomplishing almost any task we give them. They do not sit by and wait for us to call, — most of the time we are totally unaware of the multiplicity of projects in which our various county Auxiliaries are involved. In this, the House of Medicine has failed to provide more than lip service to every Auxiliary. Let us reverse this process.

The process of reorganization is almost complete — the constitution needs only to be ratified and the many changes in the By-Laws have been carefully reviewed and rewritten. The Board of Trustees is to be reconstituted by the deletion of

PRESIDENT'S REPORT

the two Vice Presidents. The Chairman of the Board should continue to be elected by the Board and should be continued for at least another two years. The Board should be able to decide within itself when the transfer of the operation of the Board meeting can smoothly be delegated to the President. *At this time*, I do not believe that the President, with all of his or her responsibilities, should be obligated to assume this additional duty. I feel certain that the House of Delegates will carefully analyze this process.

There have been no other serious or complex issues during this year. We will continue to oppose any legislative effort by limited licensed practitioners whether they be Chiropractors, Optometrists, Psychologists, or Podiatrists to mandate insurance benefits. We also oppose any further effort to expand the scope of practice of any limited licensed practitioner whether referable to allowing them expanded hospital privileges or practice in their usual setting. We also oppose granting to any insurance company a prejudiced position in dealing with the medical profession or the hospital industry.

The profession throughout South Carolina has sent a firm message to the Federal Government about our opposition to mandatory assignment on all cases. The profession certainly appears united in allowing each physician to ascertain with his or her patient the wisdom of acceptance, and he or she has demonstrated faith in their patients by uniformly accepting where there is financial need. I compliment all physicians for their individuality in preserving the normal physician-patient relationship.

I sense a renewal of interest in organized medicine at all levels from student to practicing physician. We have, as of this writing, the best membership totals which we have ever had, considering that we are only two and three-quarter

months into the year. I believe many factors are responsible for this interest, not the least of which is that we are doing things on behalf of the membership. The challenge of encouraging physicians to become members who see no value in this is ever there; I'll take up that challenge at every opportunity for I can relate that I have benefited far more from this experience this year than anyone could estimate. I have that vision of everyone having an opportunity to make one of those visits and speak to a county society. I would that the process were such that every member could be allowed this kind of involvement. You all say, thank God, he's doing this, not me. This has been the most satisfying, humbling, gratifying experience I could ever hope to have participated in. I thank you for that opportunity to serve you. I would like nothing better than to leave office knowing that there was a solid 2,500 active membership list.

I am proud of every aspect of this association. I am particularly proud of your confidence in me in having granted me the privilege of serving you during this year. I leave you with a stronger association, a more unified and participatory House with my pledge to assist you and Leonard Douglas in anyway that I can — to continue this growth.

Remember, ladies and gentlemen, you are the leaders of the House of Medicine in the State of South Carolina. The future of the Association rests directly on your shoulders. You must demonstrate this leadership to the public through and with the assistance of the media. The most important element of this is your ethical and moral relationship with your patients.

Respectfully submitted,
Kenneth N. Owens, M.D.,
President

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REPORT OF THE PRESIDENT-ELECT

My year as President-Elect has been a busy one, spent in preparing to make myself better able to represent our Association as President during 1985 and 1986. Toward this end, I felt it important to continue cultivating the favorable relationship with the media for which we have been working the past two years. I met with the SCMA Public Relations Consultant soon after last year's Annual Meeting to discuss media strategies for the then upcoming two-year period.

However, one of the major efforts this year on the part of your President-Elect has been the reorganization of SCAPELL. Most of us who are involved felt that the organization, as then constituted, was too large and unwieldy. We have discontinued the position of District Chairman and have, instead, appointed county SCAPELL Chairmen. We have assigned key legislative contacts and now feel that SCAPELL is a more streamlined and efficient tool in our legislative efforts. Thanks to all of you who agreed to serve as Chairmen and key contacts.

I have worked closely with the Legislative Activities Committee and SCMA staff in presenting to Council and the Executive Committee legislative matters in which the SCMA is interested, either in supporting or opposing. I will mention only major areas of concern in order not to duplicate the report of the Legislative Activities Committee itself.

A key thrust of our legislative efforts in this two-year session of the General Assembly is our Tort Reform Package, developed by the Professional Liability Committee of the SCMA. With the support of business and industry and health care coalitions over the state, we have high hopes that at least some of the reform measures will be successfully passed.

The Association has joined with other concerned organizations and individuals to support, in concept, the Governor's Medically Indigent Assistance Act. We have presented testimony at hearings and have offered the Governor's office and the legislature the assistance of our Committee on Medicaid and Indigent Care which has reviewed the legislation and is prepared to make comments and suggestions towards refining it.

Other key issues to which the SCMA is lending its support are the Drug Crime Bill, legislation to protect physician/patient confidentiality, Medicaid funding increases, the "Death With Dignity"

bill, and legislation to require insurance companies to pay hospital and physician bills in 15 days. The SCMA, as in the past, is in strong opposition to bills which require mandatory health insurance coverage for non-M.D. groups such as chiropractors and psychologists. We do, however, support legislation which states that bills purporting to mandate health insurance coverage in health insurance policies must include a list of the current availability, public demand and current utilization of such services. We are in support of legislation which requires that one must be 21 years of age to purchase or possess beer or wine. The SCMA is opposing a bill which would repeal the Hospital Discount Law. Please refer to the Legislative Activities Committee report for details on these matters, as well as others.

The "Doctor of the Day" program at the Legislature is in full swing at the time of this writing and continues to be very favorably received by our legislators and State House staff members. They particularly appreciate the fact that this is an effort by physicians to really address their personal health needs and that we are not using this forum to lobby them on the many issues they are considering.

The SCMA legislative reception for the entire General Assembly is scheduled for March 19 at the Holiday Inn City Center, and we hope for as good a turnout this year as was the case in 1984.

I would like to pause at this point to express our appreciation to Frank Rogers, SCMA staff attorney and state government representative for almost seven years. Frank has resigned to assume the position of Manager of Governmental Affairs for Glaxo, Inc., a national pharmaceuticals concern headquartered at Research Triangle Park, N. C. Ms. Susan Nickles, formerly with the State Chamber of Commerce, has assumed Frank's lobbying responsibilities, and we welcome her to our team. We plan to also use consultants in our lobbying efforts on an "as needed basis." In streamlining and expanding our legislative program, we have adopted a "two-pronged" attack in that we have added staff and obtained word processing equipment to get letters out quickly to the SCAPELL organization. We expect to see some very positive results from these expanded efforts.

It is the prerogative of the President-Elect to select what specific goals he would like to see the Association emphasize in the coming year. In the

Implementation Task Force Report, you will find the long range goals we approved at the last Annual Meeting. In reviewing all of these goals, I hope you will agree that we have made good progress in one short year in the majority of the areas listed. I will further address goals and directions that SCMA should pursue in the coming year.

I would like to see us continue to emphasize our activities in the Legislature as more and more issues arise which affect the way we practice medicine. We must continue our efforts in the area of public relations to achieve understanding and acceptance of the profession and the problems we face in delivering quality care in these days of cost containment when that quality care is being threatened. I feel very strongly also that we should remind ourselves of the high ethics we have always championed, and address how we conduct ourselves as a profession in the eyes of the public. We must remember that we are our patients' advocates and must protect their interests.

I feel that another of the goals we need to stress

is more physician involvement in the community welfare. We are busy physicians, but we need to serve on our School Boards, join the Chamber of Commerce, become leaders in our community activities.

With regard to providing services to our members and the medical profession as a whole, I am encouraging staff to pursue setting up practice management programs. This is an area we have neglected for the past few years.

These are some specific goals I presented to Council in March. We must remember, however, to remain flexible so that we can turn our energies to other matters which surface which must take priority.

I present this report to you today as President-Elect with the confidence that our Association is going to continue to grow and, with your help, truly attain our long range goals.

Respectfully submitted,
Leonard W. Douglas, M.D.
President-Elect

REPORT OF THE TREASURER

As I complete my first year as Treasurer of the South Carolina Medical Association, I would like to present a short report about the SCMA's financial condition. A more comprehensive report will be presented to the 1985 House of Delegates in Charleston.

For the year ended June 30, 1984, the SCMA had net expenses over revenues including depreciation of \$127,643. However, if you exclude depreciation expense of \$30,868, the SCMA had net operating expenses over revenues of \$96,775. The SCMA had a Fund Balance of \$1,201,514 as of June 30, 1984.

The SCMA's current financial condition for the seven months ended January 31, 1985 projects a more positive financial position. At the end of

January, the SCMA had earned net revenues over expenses of \$165,857. We currently project that the SCMA will have net revenues over expenses of \$225,000 for this fiscal year.

For fiscal year 1985-86, the financial affairs of the SCMA are positive. As you know, the consolidation of the staff and programs of the SCMA and its related organizations is complete. The effect of this reorganization on the SCMA's finances has been a plus. Based on the positive financial position of the SCMA we have recommended no dues increase for 1985.

Respectfully submitted,
Thomas C. Rowland, Jr., M.D.,
Treasurer

REPORT OF THE SECRETARY

Since the last meeting of the House of Delegates, the South Carolina Medical Association has seen many changes, and almost every change has improved our organization significantly. Others in the leadership have described the impact of these changes, so I would prefer to direct my comments to the one area which I now believe and will always believe is the most important part of any organization — *membership*.

It's true that we again established an "all-time" record — a total of 2,960 members in all categories of membership — a gain of 31 over our 1983 record. Happily, the largest category was active membership (full dues paying) where we netted 24 members. The real truth, however, is that we stayed the same when we consider the increased physician population in the state — about 66 percent of potential.

The early indications for 1985 show that we have an opportunity to record the first real membership gain in ten years and we are cautiously optimistic that, with your help, it will become a reality.

For a moment, let's take a look at several membership plans. Beginning in 1986 we will start billing AMA dues with SCMA dues. We are one of six states in the nation that does not do this presently. This *does not* mean that you must join both the AMA and the SCMA — it provides that option on the same statement. We will benefit in several ways: (1) we receive a commission on all AMA memberships collected by a specified date; and (2) we have the use of AMA marketing resources which should help us in reaching those members

of the profession heretofore unreachable.

It is my hope that someday we will have county, state and national on one membership effort, but my "crystal ball" is still a little "cloudy" on that dream.

There is one additional proposition that I offer now as food for thought only and not as a proposal. It's called unified membership.

The advantages resulting from the existence of the current network of medical societies — the "Federation" — are diminished by the fact that not all physicians participate in all levels of organized medicine. When a physician belongs to only one or two of the levels of medicine, those levels must fulfill for that physician the missions of the other levels, thus diverting resources from their most important roles.

The challenges facing the public and the profession in today's medical environment demand a network of medical organizations which provides representation of the highest caliber possible to physicians and their patients. Achievement of that ideal demands a commitment by leadership of medicine to enlist the support of *all* physicians for all levels of organized medicine.

Think about it — take the idea home with you and discuss it in your county and with your colleagues. I would be pleased to discuss this concept with you individually or collectively any time. Perhaps at the next Annual Meeting we can consider the proposition as "Official Business."

Respectfully submitted,
J. Gavin Appleby, M.D., Secretary

FINANCIAL CHECKUP

MARTIN LEFKOWITZ
Certified Financial Planner
Tax Shelter Co-Ordinator: E.F. Hutton

Vol. 4, Issue No. 4

April 1985

BEYOND CORPORATE BONDS

The great financial product explosion of recent years has revolutionized even traditional investment areas.

What's happened to taxable fixed income investments? In the past, these traditional vehicles, which included corporate bonds and U.S. Government (and Government agency) securities, offered high yields to investors seeking income without considering the effects of taxation. Now, however, taxable fixed income encompasses a wealth of investments that didn't even exist as little as one or two years ago. What are they and will they have a place in your financial program in 1985 and the years beyond? The following may help you decide:

*Collateralized Mortgage Obligations (CMO).

How would you like to participate in the benefits of mortgage lending without assuming many of the risks? CMOs are available for as little as \$1,000.

One of the newest products in the taxable fixed income market, the CMO combines the characteristics of a GNMA with the capital preservation feature of a put bond.

Like GNMA's, CMOs are backed by pools of mortgages that offer high monthly income -- at times, even higher than Aaa-rated corporate bonds. Unlike GNMA's, however, CMOs do not necessarily carry a government guarantee. On the other hand, they are not affected by interest rates as dramatically as GNMA's either. Monthly income consists solely of interest, not interest and principal as is the case with GNMA's. Principal paid by mortgage holders is placed in a special reserve that enables CMO investors to redeem their bonds with the issuer for par value (\$1,000). As a result, you gain peace of mind, as well as high monthly income from this exciting new investment.

*Zero Coupon Corporate Bonds.

As their name implies, these fixed income securities pay no semi-annual interest. As a result, they sell at a substantial discount from par (\$1,000). Like traditional corporate bonds, however, zero coupons pay par at maturity. As a result, investors stand to earn capital appreciation that can equal several times their original investment, depending on which maturities they choose.

Zero coupon corporates have proven extremely popular with IRA and other retirement plan investors. Their wealth of maturities enables investors to know exactly how much their investments will be worth at a specified date in the future. And because zero coupon corporates do not pay semi-annual interest, there is no risk of reinvesting interest payments in lower yielding vehicles.

*TBRs and CATs.

Combining the appreciation potential of a zero coupon corporate bond with the security of a U.S. Treasury Bond, Treasury Bond Receipts (TBRs) and Certificates

(Financial Check-up cont'd)

of Accrual on Treasury Securities (CATs) entitle you to interest or principal payments of U.S. Treasury Bonds purchased by Hutton and placed in custody with a major bank. Maturing every six months until the Treasury Bonds themselves mature, TBRs and CATs offer appreciation that may not be as dramatic as their corporate bond counterparts but which has recently equalled up to eight times original investment.

TBRs, CATs and zero coupon corporates are equally liquid; all may be sold before maturity in secondary markets maintained by Hutton. All are taxed the same way. And all may prove valuable tools for conservative investors with specific future objectives.

*High Yield Bonds.

Sometimes called junk bonds by Wall Street professionals, these popular securities are anything but. High yield bonds are rated below investment grade. What this actually means is that they are issued by companies with depressed earnings and, therefore, offer higher yields than are available from the bonds of more financially stable organizations. Because they represent a debt obligation, however, high yield bonds may offer more safety than comparable common stock. And more importantly, high yield bonds offer the opportunity for substantial capital appreciation in two ways. The value of your investment increases as interest rates fall. And if the issuer experiences a financial turnaround, the rating of its bonds (and, therefore, their price) should rise.

Taxable fixed income products are becoming increasingly able to meet the investment goals of a broadened segment of the population; young and old, conservative and aggressive, for the short- or long-term. And their variety keeps growing. Whatever your investment needs, 1985 may be the year to include one or more of these high yielding vehicles in your financial plan.

*Lest We Forget.

With all the new taxable fixed income investments currently available, it's easy to relegate corporate bonds to the investment hall of fame -- valuable in a bygone era but obsolete in today's economic environment.

Not so fast. There's life in this traditional investment yet.

With interest rates having trended down since last June and the inflation rate holding steady at 4%-5%, the real rates of return offered by corporates are higher than they've been in years (real rates are determined by subtracting the inflation rate from the rate of return provided by your corporate bond).

Corporates don't only come in the high yield variety described above. A wide variety of ratings and maturities are available to meet your individual needs and outlook for the economy over the short and long term.

FURTHER INFORMATION

If you would like to receive further information on any of the topics covered in this newsletter, please write to Martin Lefkowitz, CFP, E.F. Hutton & Company, 2700 Middleburg Drive, Suite 200, Columbia, SC 29204; or Call (800) 922-1112.

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REPORT OF THE CHAIRMAN OF COUNCIL

Thank you, Mr. Speaker.

Members of the House of Delegates, officers and members of the SCMA, guests, ladies and gentlemen: I thank you for the opportunity and the pleasure of bringing to you the report of the Chairman of Council of the SCMA.

During the past year the Council of the SCMA has been extremely active and I encourage you to join me in expressing our gratitude to the members of Council who have taken time out of their busy schedules to represent you. As Chairman of Council, I am very aware of the effort this group of physicians has put out on your behalf. You are to be commended for sending to Council such excellent representation.

Not to be forgotten are the committee chairmen and members who deal with continuing issues and also catch the brunt of the work created by Council. Many meetings and many hours by the 36 committees and the approximate 400 physicians who serve on them have been invaluable. The officers of the SCMA and Council thank you for your effort.

Your state society has also been served well by its subsidiary organizations. The Members' Insurance Trust, S. C. Institute for Medical Education and Research, S. C. Medical Building, Inc., S. C. Medical Care Foundation and SOCPAC have had dedicated leadership and boards and have been active forces on your behalf. Their reports are included in your handbook.

In this past year, the Association has faced changes internally and externally unprecedented in our history. These changes reflect the growth of our organization and our expanding involvement in key issues facing our local communities, our state, and our nation in the area of health care.

We, the physicians in this state, are actively involved in these key issues and are able to be so not only because of the above mentioned officers and committees, but because of a staff second to none. Under the leadership of the Executive Vice President, Mr. William Mahon, I can report to you we are secure in our staff support. I urge each of you to support them and join with Council in expressing heartfelt thanks for a job well done.

A major effort on the part of the Association this past year has been on activities related to the Medicare provisions of the Deficit Reduction Act of 1984. As you know, the AMA, last fall, challenged the constitutionality of certain provisions in

the Act by filing suit in the U. S. Federal Court for the southern district of Indiana. At the time of this writing, we are awaiting the decision of Judge Sarah Evans Barker on this issue. The SCMA joined with other state and specialty societies in supporting this action.

The freeze on physicians' fees for the treatment of Medicare beneficiaries and the "participating" physician provisions resulted in much confusion on the part of physicians and elderly patients alike. The list of Medicare "participating" physicians, as published by the Medicare intermediary, reflected many errors. Many patients felt they were forced to choose another physician if theirs had chosen not to enroll as "participating."

Council approved a survey of all SCMA members to ascertain if they would accept Medicare patients, either as "participating" physicians or on a case by case basis as individual circumstances dictated. The result was a list of approximately 1,500 member physicians which was compiled into a booklet for distribution to any Medicare patient requesting it. Newspaper advertisements in all daily newspapers in the state and in publications directed to the elderly resulted in many requests for the booklet.

We hope, as outlined in the booklet preamble, that this booklet will allay some of the doubts and answer some of the questions in the minds of our patients that our concerns are for them and for the continuation of the personal physician/patient relationship which has been so threatened by governmental intervention.

Also in the area of federal legislation, the SCMA joined with other state and specialty organizations and the AMA in vigorously opposing the "physician attestation" statement associated with the DRG payment system. The final rule was published in August and is a substantial improvement over the original documents. Despite this improvement, however, and the fact that the AMA argued the statement was "inappropriate and unnecessary," the statement remains as yet another reminder of the encroachment of the federal government into the private practice of medicine.

Another area of consideration over the past year for Council has been alternate delivery health care systems. The Task Force on Alternative Delivery Health Care Systems has a report

CHAIRMAN'S REPORT

before you for your consideration. Council urges your approval of its recommendations.

The SCMA Leadership Conference, recommended by our illustrious Past President's Club and supported by Council was organized and held on February 27 this year. I am pleased to report that it was well-attended and well-received, and we hope the leaders in our county societies and auxiliaries will benefit from the educational opportunities that were presented. After the conference an informal reception and tour of the new SCMA Headquarters Building on Fernandina Road in Columbia was held. The report of the Chairman of the Building Corporation will fill you in on the details of our debt-free, completely remodelled building.

Problems with Blue Cross and Blue Shield continue to arise and receive the full attention of your Council. We have supported the Members' Insurance Trust Board of Directors recommendation that our agreement with Blue Cross and Blue Shield to handle the claims administration of our Trust be discontinued. We have endorsed their proposal that Provident Life assume this responsibility and the change took place as of February 15 this year.

Arising from the discontinuance of our agreement with the Blues was a questionable "marketing" strategy on their part of using our subscriber list to solicit members for their health insurance program. In their solicitation letter, there was an erroneous implication that MIT members would no longer have health insurance coverage. Council expressed serious concern over this type of "marketing" technique and filed a formal complaint with the South Carolina Insurance Commissioner. SCMA also sent out a mailing to the membership explaining the situation.

Council has been intensively involved in legislative matters on the state level and we call your attention to the report of the President-Elect and the Legislative Activities Committee for details. Of major concern is the SCMA Tort Reform package. In addition, as detailed in the report of the Committee on Medicaid and Indigent Care, we are supporting the concept of the Governor's Medically Indigent Assistance Act.

The SCMA improved its relationship with the Governor's office and the state legislature by taking an active stance up front on key issues such as the Medically Indigent Assistance Act. By supporting the concept of these issues early, we be-

come part of the process and are seen in a much better light.

You are all aware of the malpractice problem that faces all of us across the nation. I want to take this opportunity to commend the Risk Management program we are fortunate to have in South Carolina. The committee has maintained an effort which has had obvious effects as witnessed by the large turn out for the last Risk Management Seminar.

I will not include in this report any administrative matters for your consideration. We feel that administrative details are in the hands of our well-qualified Executive Vice President and his staff, and Council has, for the most part, turned our attention to conducting the business of the Association.

I will not attempt to report to you all the endorsements, appointments and co-sponsorships we have approved. There have been many. I would like to present a brief outline of some of the issues addressed by Council during the past year. Council has: with the South Carolina Hospital Association established media guidelines in the hospital setting; opposed non-MD status of the Commissioner of Mental Health; established a goal of 3,000 full members by the end of 1987; supported the foundation's 3.7 million dollar contract with the federal Health & Human Services Department; established a liaison between SCMA and the state Health and Human Services Commission; monitored the strength of the JUA/PCF program; supported the Dental Association as outside forces attacked their method of licensure; supported resident and student delegates to the AMA; supported the concept of a "voluntary freeze" on physicians' fees; responded to DHEC on numerous occasions, such as the issue of responsibility in pronouncement of death and signing of death certificates in nursing homes; supported the Governor's Medically Needy Program, after much work by your Committee on Perinatal and Maternal Health; agreed to co-sponsor with the Auxiliary a Conference on Child Abuse to be held in October, 1985 (tentative); sent a representative to the Interagency School Health Committee; initiated dialogue with state and local law enforcement agencies on several issues; supported the AMA position on dual-routes to licensure; received a report from the Chairman of the Committee on Alcohol, Drug Abuse and Impaired Physicians and endorsed that program; supported

the Board of Pharmacy in several of their efforts; opposed the repeal of the Hospital Discount Law; supported a Medical Examiners system; supported the Auxilliary in many efforts; received reports from all committees and acted on many items generated by them; and met quarterly with the Executive Committee of the South Carolina Hospital Association.

The above items represent a small portion of the issues addressed by your Council and Executive Committee. They are intended to give you an idea of the magnitude and diversity of the issues your staff and Council address. Many issues are urgent and handled by phone conference on an interim basis. Many times your officers and committee members have to travel across this state in response to urgent situations. Yours is an active organization. Several good sources of information about these issues are the "SCMA Newsletter" and the "Legislative Update." I urge you to read them.

On the AMA level you have reason to be proud. Your delegation to the AMA is well-known. Tucker Weston, M.D., is currently the Chairman

of the Southeastern caucus and John Hawk, M.D., is Vice Chairman of the AMA's Council on Constitution and By-Laws. Randolph Smoak, M.D., is now a member of the Board of AMPAC. If you have any idea of AMA politics you know how impressive that is. Marcus Newberry, M.D. ran a good race for the AMA Council on Medical Education and plans to run again. Your Executive Vice President, Bill Mahon, and Executive Director, Bill Watson, are well-known and respected on a national level.

Council voted that a report from the Long Range Plan Implementation Task Force should be presented to you after my Chairman's Report. Before I turn the Report over to the Chairman of the Long Range Plan Implementation Task Force, Leonard W. Douglas, M.D., I want to again thank all of those individuals I mentioned before and especially the staff for a banner year in the history of the SCMA. Thank you.

Respectfully submitted,
Charles R. Duncan, Jr., M.D.
Chairman of Council

REPORT OF COUNCILOR, FIRST MEDICAL DISTRICT, METROPOLITAN

I take this opportunity to thank the Metropolitan District Membership of Charleston County for allowing me to serve as their Councilor this past year. It has been a full and rewarding year. The Charleston County Medical Society has been very active in setting up a voluntary health care program for the medically indigent patients and hopefully by the time this report is published, there will be such a plan in Charleston County.

The membership of the Charleston County Medical Society continues to increase, as many new physicians move into practice in our metro-

politan area.

The full time faculty at the Medical University Hospital is becoming more involved with workings of the Charleston County Medical Society and, hopefully this can be translated into a closer working relationship on the part of the full time faculty of the Medical University with the South Carolina Medical Association.

Thank you for your courteous attention.

Respectfully submitted,
Bartolo M. Barone, M.D.

REPORT OF COUNCILOR, SECOND MEDICAL DISTRICT, METROPOLITAN

I would like to thank the physicians of the Second District for allowing me to serve as their Councilor for the past year. It has been a very educational experience.

The Second District has lost several physicians in the past year and these will be sorely missed by their colleagues. I feel that I would be remiss if I do not remember Dr. Buford Chappell, Dr. John Harvin, and Dr. Emmett Lunceford at this point.

The physicians in the Lexington-Richland area of the Second District this past year have formed an IPA-HMO. It was organized and is controlled by physicians. To my knowledge, it is the first HMO in South Carolina that has been organized by physicians and is to be controlled by physicians. The Board of Trustess will have ten physicians and five consumers on the Board and thus far approximately 400 physicians have signed up with this HMO. The membership is looking forward to working with the different businesses in the state in an effort to control rising health care costs.

Respectfully submitted,
B. Daniel Paysinger, M.D.

REPORT OF COUNCILOR, SECOND MEDICAL DISTRICT

For the 1984-85 Councilor year, my activities have been focused on disseminating cost containment information in my district. Working with our county medical society, we have endorsed the Spartanburg Plan and promulgated it to local service organizations as personal presentations. We are following through with letters with each of the major industries, the Council on Aging, etc., offering to be available for a resource role as they plan to rationally contain the cost of health care for their constituents.

Our district has been particularly favored by having the President from our area this year.

I look forward to seeing you all at the state meeting.

Respectfully submitted,
Jack L. Ratliff, M.D.

REPORT OF COUNCILOR, FOURTH DISTRICT, METROPOLITAN

I would like to take this opportunity to first express my appreciation to the House of Delegates and the membership from the Metropolitan area of the Fourth District for the privilege of serving our association as Councilor for the Fourth Medical District.

I had the distinct pleasure and honor of being elected Chairman of Council at the reorganizational meeting of Council following our last annual meeting.

Council has had a busy and productive year and it has been a pleasure working with your officers, councilors, committees and staff. I have attended and chaired every meeting of the Council and Executive Committee. Many hours have been spent on the phone and attending to other duties on your behalf. My report as Chairman of Council is documented elsewhere in your handbook.

The Fourth Medical District is active in many affairs of a local and state nature. Its members participate in community activities and support the local medical society and the state society by serving on many committees and chairing several. Your President-Elect, Leonard Douglas, M.D., is from this district and our own Mrs. Wayne (Billie) Brady is the national President of the AMA Auxiliary.

I see evidence of our society's increasing activity in the areas of cost containment issues and exploration of alternate forms of health delivery systems. I have every confidence that as a profession we have the ability to respond to the needs of our patients and the forces of change.

I look forward to continued service on your behalf and thank all of you and especially the Council, committees and staff of the SCMA for your efforts and commitment to the SCMA.

Respectfully submitted,
Charles R. Duncan, Jr., M.D.,

COUNCILOR REPORTS

REPORT OF COUNCILOR, FOURTH MEDICAL DISTRICT

For the 1984-1985 Councilor year, I have been involved in learning the functions of Council and the various activities with which they have had to deal. I have attended all the Council meetings, including the Council Retreat at Hilton Head in October. I also attended the Risk Management Seminar in Columbia on February 20, 1985; the Leadership Conference, February 27, 1985; and was Doctor of the Day on February 21.

We were pleased to have our President, Dr. Kenneth Owens, and Mr. Mahon meet with the Pickens County Medical Society in October. The society was informed about the current HMO and PPO efforts in the state.

I've attended the Anderson County Medical Society meeting in January, 1985 and have been in contact with the Oconee Medical Society, but have not yet been able to attend one of their meetings.

Respectfully submitted,
William J. Goudelock, M.D.

REPORT OF COUNCILOR, EIGHTH MEDICAL DISTRICT

In my first full term as Councilor of the Eighth District, I attended all Council meetings including the Council Retreat at Hilton Head.

Dr. Owens honored the Edisto Medical Society by attending our October meeting, presenting the main address to that body and answering questions concerning the SCMA.

All delegates to the SCMA 1985 Annual Meeting from the Eighth District have been selected and their names reported to the Speaker of the House of Delegates.

All component counties of the Eighth District have been contacted and the services of the Councilor offered to report on Council activities.

Respectfully submitted,
John W. Rheney, Jr., M.D.

REPORT OF COUNCILOR, FIFTH MEDICAL DISTRICT

During the past six years, I've had the opportunity of representing the Fifth Medical District of South Carolina on Council. During this time, I've had an opportunity to visit and to get to know a number of members of the South Carolina Medical Association from throughout the district and I have found this to be quite a pleasant and enjoyable experience.

Also, during the last two years I've had the opportunity of serving as Vice Chairman of Council and a member of the Executive Committee. During this time I've been very impressed with the quality and dedication of our staff of the greater South Carolina Medical Association as well as my fellow members on the Council and the Executive Committee. I have felt this to be a rare opportunity to serve and I certainly treasure my many new friends and applaud them for their service to the South Carolina Medical Association and the many activities which the South Carolina Medical Association finds itself involved in.

According to the present Constitution and By-laws, my term on Council must end at the end of my current term. However, I do plan to continue to serve as a member of the Board of the South Carolina Medical Care Foundation, and also on the SOCPAC Board where I'm currently serving as Vice Chairman.

I would like to thank the members of the Fifth District for the opportunity which they have given to me to serve and I pledge my support and any help which I might have to offer to the newly elected Councilor from this district.

Respectfully submitted,
William M. Hull, Jr., M.D.,
Councilor

COUNCILOR REPORTS

REPORT OF COUNCILOR, NINTH MEDICAL DISTRICT

This has been a very busy and productive year for the constituency of the Ninth Medical District.

With the Spartanburg County Medical Society leading the way, we have been a very visible and vocal force in cost containment efforts. To encourage the development of the private review concept, the county society is offering a five percent discount on the professional component of hospital charges. This proposal, it is hoped, will be an incentive for participation by business and industry.

Recognizing the importance of good relations, a seminar was held in Spartanburg in January of this year. Relationships with radio, television and area newspapers were discussed in-depth. We are already heavily involved with physician participation on radio and television programs. The

county society's Public Relations Committee provides a helping hand to obtain physicians who are needed for specific requests and the Spartanburg County Society publishes a bulletin that is distributed approximately every two months.

We are also cooperating with area medical auxiliaries in promoting programs and seminars relating to child abuse. Physician awareness of this very tragic problem is being stressed.

Members of the district have also been active participants on the SCMA Legislative Activities Committee. During the past year the Spartanburg County Medical Society sponsored a dinner for our legislative representatives. We currently feel that we have good rapport and an excellent line of communications with our representatives.

I appreciate very much all those who have served on committees and who give so invaluable of their time.

Respectfully submitted,
J. Sidney Fulmer, M.D.

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Our Private Clients receive assistance and direction in setting financial goals, determining the proper investment mix for their assets, and implementing and monitoring the chosen **strategy**.

Generally, our Clients were **sick and tired** of being sold investments in the past by others without any consideration of the long-term effects on their financial situations. They now place their trust and confidence in us to create a sense of purpose and continuity in their financial lives where there was none before.

So whether you have heard of us or not, realize that someone else in South Carolina has. About **165** doctors and other "someones" to be precise. If you would like to make your net worth numbers more impressive through strong, capable investing, then you should try these impressive numbers: **(803) 577-7099**.

FINANCIAL ASSET MANAGEMENT Advisory

151 Meeting Street, Suite 450, Charleston, SC 29401

Robert W. Pearce
Lucian W. Pinckney

Wm. O. Hanahan, Jr.
Catherine C. Gamble

Robert W. Pearce, Jr.
Robin L. Baldock

REPORT OF THE IMPLEMENTATION TASK FORCE

As you may know, Council voted last October that the Long Range Strategic Plan Implementation Task Force should remain as originally constituted until the Task Force or Council felt it was no longer needed. Council also voted that a report should be presented to this House of Delegates in order to bring you up-to-date on what had been accomplished and what remains to be done. The Long Range Strategic Plan covers an approximate five-year period, and the Task Force is charged with seeing that the recommendations therein are carried out.

I am pleased to tell you that, at this Annual Meeting, phase one of the Long Range Strategic Plan will be completed. The Constitution which lies on the Table for final action at this meeting reflects the reorganization of our association, incorporating into the SCMA our affiliates and subsidiaries and merging the staffs into one single unit prepared to serve any of the affiliates and subsidiaries in whatever capacity is needed. Also presented for your consideration are the SCMA Bylaws, a document based on the principles in the Constitution and on the recommendations of the Long Range Planning Commission, the SCMA Council, the Implementation Task Force and sub-Task Forces and, of course, the Committee on Constitution and Bylaws which is to be commended for its efforts in what must have been a tedious undertaking.

Included in the Bylaws is reference to a separate document outlining criteria for SCMA leadership positions. The Task Force and Council feel these criteria merit your special consideration since your future leaders will be chosen based on the concepts outlined therein.

The SCMA goals, as specifically stated in the Long Range Strategic Plan, are included on the attachment. I believe you will agree that we have made significant progress in the majority of the areas listed, and I have detailed in my President-Elect's Report those specific issues I would like to see stressed in the upcoming year.

The specific Growth and Development Strategies to achieve these goals, as included in the Plan, are listed below, with some progress notes indicated.

1. Strengthen governmental representation.

As reported to you elsewhere, SCMA lobbying staff and activities have been increased, and addi-

tional word processing equipment purchased to streamline our communications to SCAPELL and to the membership. You will note also in the SOCPAC report that this organization has been strengthened and a new membership category established. SCAPELL has been reorganized into a smaller, more viable group which we feel will carry out our "grass roots" legislative efforts more effectively. There is, of course, work to be done in our legislative program, particularly in view of the fact that we lost several key legislators in the last election who were favorable towards the medical profession. This is an area which we cannot and will not fail in assuring that it receives our concentrated attention and efforts.

2. Develop a strong public relations program.

I believe all of you will agree that our public relations efforts, especially compared with just two short years ago, have been significantly increased. Our relationships with representatives of the media have received close attention, including visits by the President to major editorial staffs of daily newspapers, a Media Relations Workshop during the Council Retreat last fall, and just recently, a Media Relations Seminar during the SCMA Leadership Conference in late February. We feel that SCMA staff is becoming more and more knowledgeable and expert in the public relations area and that we can now use a public relations consultant only on an "as needed" basis.

3. Develop plan to address the reimbursement and payment issues facing physicians.

This is an area which we will probably be addressing for many years to come, as the environment in the area of delivery of health care continues to change. Elsewhere in your handbook is a report from the Task Force on Alternate Health Care Delivery Systems, and I would call your careful attention to this report. Included as a recommendation for this Strategy 3 was that the SCMA should improve communication and liaison with third party payors. It became necessary that the Members' Insurance Trust change its administrator for claims to another insurance company. We feel, however, that this step was necessary and was based significantly on the feelings of individual physician members from over the entire state.

IMPLEMENTATION TASK FORCE

4. Take steps to maintain quality care in changing environment.

We have continued good rapport with both medical schools in the state and are pleased that the Deans have joined us for several Council meetings to discuss matters of mutual interest and concern. We have always supported our State Board of Medical Examiners and will continue to provide them with our encouragement and endorsement. We continue to monitor the activities of non-physician health care providers to ensure the delivery of quality health care, just as we continue to monitor physician activities through peer review.

5. Evolve a plan to address malpractice problems.

Through our Risk Management Program, we feel we are making some progress in this area. The major effort, however, has been through our Professional Liability Committee's Tort Reform proposals which are being introduced in the Legislature during this session. We have reported this activity to you through several other avenues and I am sure you will study the various reports carefully.

6. Expand and improve efforts to monitor the changing environment and communicate trends to members.

More issues of a socioeconomic nature are now being included in our *Journal* and the "SCMA Newsletter." Other plans include periodic assessments of the health care environment in the state, including a survey of at least a sample of member and non-member physicians. We also plan to develop a "red alert" publication to cover important issues, and a special information program for hospital chiefs of staff to keep them informed about trends in the changing relationships between hospitals and physicians. Our joint program each fall with the Hospital Association addresses this specific issue.

7. Expand membership and increase membership participation.

Elsewhere in your handbook you will see the report of our Secretary and you will note that we are well ahead on 1985 membership (active) over 1984. We are very gratified with this progress but will not let up on our efforts to recruit new members, particularly the new physician in his first

year of practice. With regard to membership participation, as President-Elect I have made committee appointments this year with a goal towards involving more members and rotating off those who have served us well but were willing to move aside. We made few changes in our committee structure last year because of our reorganization, but this year we felt confident that it was time to disband those committees which were no longer active or whose duties were completed. By concentrating on the work of those committees which are vital to our organization and by assuring that committee members are interested and willing to serve, we feel greater involvement and greater progress can occur. As mentioned elsewhere, staff is being encouraged to schedule Practice Management Seminars aimed at the new physician. We feel this is an important, but neglected area which we have not addressed as we should have.

With regard to the administrative details of our Long Range Plan and the reorganization of staff, I refer you to the Report of our Executive Vice President, Mr. Bill Mahon. We congratulate him on the job he has done in a very short period of time.

We will continue to make periodic reports to Council (soon to be Board of Trustees) and to the House of Delegates each year, as long as our Implementation Task Force remains necessary and active.

Respectfully submitted,
Leonard W. Douglas, M.D.,
Chairman, Implementation
Task Force

SCMA GOALS

The Planning Commission also discussed and evolved a set of goals for SCMA which are appropriate to ensure that it fulfills its mission. These goals are the following.

1. Champion freedom in medicine in order to preserve the right of physicians to choose their practice and patients to choose their physicians.
2. Seek to ensure that the physician remains the leader of the health care team addressing the health needs of the citizens of the state.
3. Promote and support good health practices and quality health care for citizens of the state, encouraging physician involvement in the community welfare.

4. Promote high professional standards and ethics in medical practice.
5. Seek policies for quality, cost-effective, and accessible medical care with fair payment for physician services.
6. Seek to achieve public understanding, acceptance and support for the medical profession and the complexities of delivering quality medical care.
7. Promote quality medical education and research, consistent with the medical manpower and research needs of the state.
8. Represent the interests of physicians and quality medical practice to all organizations and groups involved in health care.
9. Maintain active participation in legislative and governmental matters which affect the medical profession.
10. Provide timely information to members on events and actions which have implications for physicians and the medical profession.
11. Provide services to meet the needs of the medical profession and physicians in the state.
12. Provide for effective communication and interaction among physicians and maintain a network for united physician actions.
13. Provide educational opportunities to meet the identified needs of South Carolina physicians.
14. Achieve membership growth and active membership participation in the affairs of the association.
15. Maintain adequate financing and efficient operations for the association to ensure the cost-effective delivery of services to meet member needs.

REPORT OF THE PAST PRESIDENTS' CLUB

The Past Presidents' Club's first meeting was held during the Annual Meeting in Charleston, April, 1983.

The South Carolina Medical Association probably has more past presidents alive than any other state society in the nation, with the possible exception of California.

The purpose of the organization is advisory only. It does not become involved in political or office holding races within the SCMA.

The Immediate Past President of SCMA will automatically become Chairman.

Recommendations made at the 1983 meeting were developed and presented at the 1984 meeting with additional activities: (1) Physicians were to be encouraged to participate in an ongoing liaison with grammar and high schools in their respective counties to improve the public image and also serve on local school boards. After approval by Council and referral to the Public Relations Committee the film, "The Making of a Physician," was sent to the South Carolina Department of Education for use in career planning.

In continuing liaison, the Public Relations Committee also polled the members of the Past Presidents' Club for those who would be willing to work with the PR Committee when matters of mutual concern arise on a local level and in assisting with presentations of the film. There were thirteen positive responses received. (2) A need for more interaction with the local county medical societies was presented to Council and approved to hold a Leadership Conference in Columbia with county medical society officers on SCMA's operations, their responsibilities and dealing with problems on a local basis. The conference was held February 27 with guest speakers and a Media Relations Workshop included in the conference. (3) A proposal by the club of having pictures of all past presidents for appointments in the Board Room at the new location of SCMA Headquarters was also approved by Council and is well underway at this time.

Respectfully submitted,
Randolph D. Smoak, Jr., M.D.,
 Chairman

REPORT OF THE EDITOR OF THE JOURNAL

This year marks the 80th anniversary of continuous publication of *The Journal of the South Carolina Medical Association*. Our Journal, among the nation's oldest of its kind, remains alive and well and for this I would like to thank especially the members of our Editorial Board and our Managing Editor, Joy Drennen.

Recommending the founding of a state journal in 1900, the SCMA president exhorted members: "Let us no longer bear the stigma of leaving no record of our deeds." It continues to be our philosophy that a state medical journal should be just that . . . a journal reflecting uniquely on the practice of medicine within its state's boundaries. Therefore, our editorial policy has been to encourage four major types of articles: (1) original scientific articles by South Carolina practicing physicians; (2) review articles by our state's academic physicians of potential usefulness to practitioners; (3) reports from the Department of Health and Environmental Control and other agencies providing data especially applicable to the health of South Carolinians; and (4) articles devoted to social, economic, legal, and political issues of particular relevance to our state's practitioners.

Over the past eight years, our policy of encouraging especially original articles by practicing physicians appears to have been successful. During the most recent two-year period (1983-1984), 45 percent of our articles (exclusive of symposium issues) have been written by practicing physicians compared to 25 percent of the articles published during 1977-1978 (chi-square = 7.3, p. (0.01)).

We would like to receive an even greater number of articles from practicing physicians . . . both original scientific observations including case reports and also "special articles" devoted to socioeconomic issues. We recall that on our fifth anniversary, in 1910, the editors urged "upon every man the importance of contributing his share."

We plan to continue our policy of encouraging special symposium issues orchestrated by our state's specialty organizations, and welcome suggestions regarding topics which might be of particular educational value.

Joy Drennen has done a splendid job with our advertising program. Advertising revenues during 1984 were increased 12.2 percent compared to the previous year. We are also pleased to report that our current income exceeds our budget projections while our expenses are below our budget projections.

This report would not be complete without mentioning the Thomas A. and Shirley W. Roe awards, amounting to \$3,000 and given on alternate years to a practicing physician or to an academic physician. These awards are, to our knowledge, unique among state medical journals. All contributors to *The Journal* become eligible for these awards.

Again, it has been a privilege to serve as editor of *The Journal*.

Respectfully submitted,
Charles S. Bryan, M.D., Editor

REPORT OF THE EXECUTIVE VICE PRESIDENT

My first year as your Chief Executive Officer has passed very quickly with so many significant events that only in sitting down to write this report has the magnitude of this year really come into perspective.

The reorganization of staff from diverse organizations with duplicate functions into a single entity has been an ongoing process for a number of months. I believe the major changes in organization have now been accomplished and the next 12 months will be spent fine tuning the organization to achieve our primary goal of providing the service that you, the membership, deserve from your medical association.

The Association, under the direction of Mr. William Watson, has achieved a new vitality that is demonstrated by increased membership, unprecedented increases in SOCPAC monies, increased involvement by medical students, improved communication with the membership and an improved legislative liaison program. All this and more has been accomplished while reducing the budget. A Risk Management Seminar was conducted, which attracted over 200. Our first annual leadership conference was held and was a great success. Member services such as the IN-TRAV travel tours, the Retired Lives Reserve and the IC Systems collection services are being utilized at ever increasing rates.

The Foundation, under the direction of Mrs. Barbara Whittaker, was awarded the first PRO contract in the nation on July 1, 1984. The concept of peer review as an integral part of physician cost containment efforts has been recognized in the joint project between the Foundation and the Spartanburg County Medical Society. As a result of this project, private review under physician direction is being provided to over 20 South Carolina corporations.

A large portion of my time was spent on the activities of the Medical Building Corporation. Two significant undertakings were accomplished this year. The first was selling our building on Medical Park Road, buying and remodelling the building on Fernandina Road and moving. The second was dismantling a significant portion of our data processing operations due to the change

in Federal Peer Review requirements from 200 PSRO's to 54 PRO's. The PRO's being large enough to support their own computer operation left us with no market except to support, under contract, our own PRO.

The Members' Insurance Trust made two changes, the results of which are not available as I write this report, but should be available at Annual Meeting. The first change was the selection of a new carrier to service the contract. The MIT changed from Blue Cross to Provident Life and Accident for administrative services. In addition, the MIT Board adopted and implemented an age banded rate structure, which reduced the premiums of most of our insureds.

In an effort to establish the Medical Auxiliary as an integral part of the SCMA's activities, we have, for the first time, provided a part-time staff director to work with auxiliary leaders and to coordinate their activities with the SCMA. The MED-VOTE Project that the Auxiliary undertook is a fine example of how the spouses of physicians can support the goals of organized medicine.

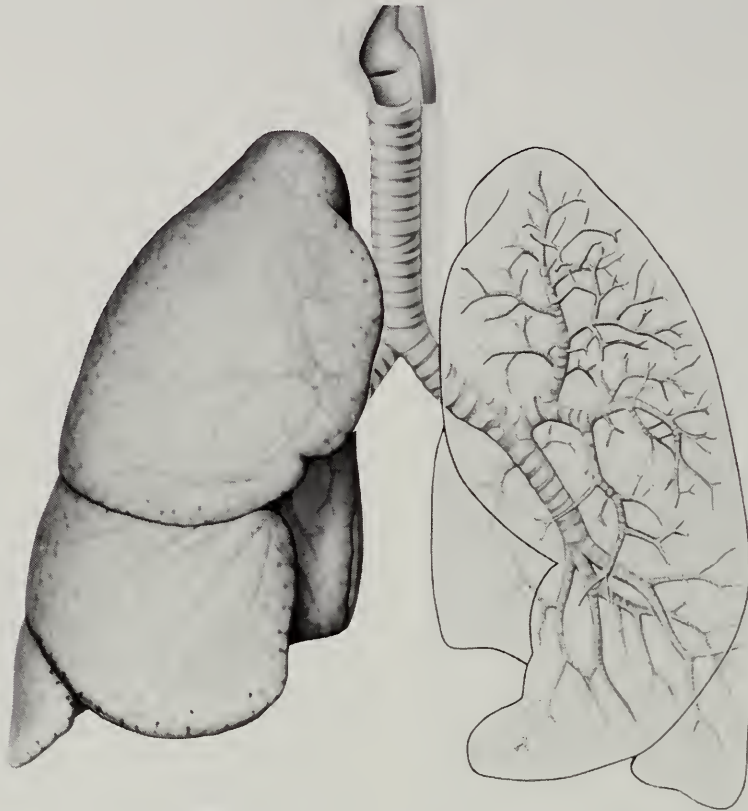
In addition to being personally involved in the above activities, I found time to visit, on more than 20 occasions, county medical societies or medical staffs around the state. The topics of discussion ranged from HMO's to PPO's to professional liability. I have enjoyed this opportunity to get out and meet the membership and hope that you will continue to invite me on a regular basis.

I would like to refer you to the other reports you have received, which highlight additional activities and achievements of the SCMA. The financial reports show that all our organizations are fiscally sound and operating in the black, we find that significant progress is being made toward accomplishing the goals of our Long Range Strategic Plan, and the list goes on and on.

Finally, on behalf of the entire staff, I would like to express our sincere thanks for your support and for giving us the opportunity to participate with you in the SCMA.

Respectfully submitted,
William F. Mahon,
Executive Vice President

Consider the causative organisms...



Cecilor[®]
cefactor

250-mg Pulvules[®] t.i.d.

**offers effectiveness against
the major causes of bacterial bronchitis**

H. influenzae*, *H. influenzae*, *S. pneumoniae*, *S. pyogenes
(ampicillin-susceptible) (ampicillin-resistant)

Brief Summary Consult the package literature for prescribing information.

Indications and Usage: Cecilor* (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cecilor.

Contraindication: Cecilor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cecilor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins). Therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics. Such colitis may range in severity from mild to life threatening.

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis.

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone. In moderate to severe cases, manage-

ment should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C. difficile*. Other causes of colitis should be ruled out.

Precautions: General Precautions — If an allergic reaction to Cecilor* (cefactor, Lilly) occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids. Prolonged use of Cecilor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antioglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Cecilor should be administered with caution in the presence of markedly impaired renal function. Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended. As a result of administration of Cecilor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clintest[®] tablets but not with Tes-Tape[®] (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.

Usage in Pregnancy — **Pregnancy Category B** — Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum

human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Cecilor* (cefactor, Lilly). There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers — Small amounts of Cecilor have been detected in mother's milk following administration of single 500-mg doses. Average levels were 0.18, 0.20, 0.21, and 0.16 mcg/ml at two, three, four, and five hours respectively. Trace amounts were detected at one hour. The effect on nursing infants is not known. Caution should be exercised when Cecilor is administered to a nursing woman.

Usage in Children — Safety and effectiveness of this product for use in infants less than one month of age have not been established.

Adverse Reactions: Adverse effects considered related to therapy with Cecilor are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70).

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment. Nausea and vomiting have been reported rarely.

Hypersensitivity reactions have been reported in about 1-5 percent of patients and include morbilliform eruptions (1 in 100), pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cecilor. Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have

occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain — Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic — Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic — Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal — Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[061782R]

Note: Cecilor* (cefactor, Lilly) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Cecilor is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

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REPORT OF THE COMMISSION ON SOCIOECONOMIC AFFAIRS AND EXTERNAL ACTIVITIES

The Commission on Socioeconomic Affairs and External Activities is composed of the following committees:

Professional Liability Committee — Euta M. Colvin, M.D., Chairman

Liaison Committee on Health Systems Agencies — Fred Phillips, M.D., Chairman

Public Relations Committee — James L. Haynes, M.D., Chairman

Medicaid and Indigent Care Committee — William H. Hester, M.D., Chairman

Specialty Society Advisory Committee

The first four committees have been very active throughout the year. The last has been relatively

inactive. It is a function of this Commission to ensure that the Council and Executive Committee charges are discussed and acted upon. The Commissioner may add his verbal comments to the Council or the Executive Committee as he deems appropriate. I have enjoyed being the Commissioner this last year and appreciate the work of the various committees and especially the Chairmen as well as staff assigned to this Commission, Bill Mahon, Joy Drennen and Donna Houston. They are all to be commended for a job well done.

Respectfully submitted,
Bartolo M. Barone, M.D.,
Commissioner

REPORT OF THE COMMISSION ON PUBLIC AFFAIRS AND PROFESSIONAL RELATIONS

The Commission on Public Affairs and Professional Relations functions to coordinate the activities of the following committees: Legislative Activities Committee, the Committee on Constitution and Bylaws, the Mediation Committee, the Committee on Alcohol, Drug Abuse and Impaired Physicians, and the South Carolina Political Action Committee (SOCPAC).

The Legislative Committee has a new chairman this year, Frank Young, M.D. Major legislative issues this year include Tort Reform Proposals, Hospital Discount Law, Insurance Equality on Mandated Benefits Legislation, Legislation to Delete Requirements of having a M.D. as Commissioner of Mental Health, Confidentiality Legislation and Indigent Care Legislation. It is still too early in the legislative session to know how much of this is going to come out. There is widespread support for passage of Indigent Care Legislation, but recently Mr. Tom Mangum, Chairman of the House Ways and Means Committee, has said that there is no money for indigent care this year. Tort Reform will probably be vigorously opposed by the trial lawyers. Our programs will be especially hard to complete because some of our previous supporters in the Legislature were defeated in the

November elections.

Frank Rogers, our lobbyist and attorney, has resigned. Bill Mahon has spent a great deal of his time with the legislature, and Ms. Susan Nickles has been hired as a replacement for Frank.

SCAPELL activities are extremely important this year because of the elections of so many new legislators who have not been informed of our position on these issues.

SOCAP continues to support political candidates who we believe will be helpful to us. We continue to have difficulty in getting SCMA members to join SOCAP and we urge those members who have not signed up to do so immediately.

The Committee on Alcohol, Drug Abuse and Impaired Physicians continues to be very active under the leadership of Dr. Grimbball. We urge you to contact this committee if you know of a physician who needs help.

It has been a pleasure to serve as your Commissioner during the past year. I look forward to continuing to serve the SCMA.

Respectfully submitted,
Benjamin E. Nicholson, M.D.
Commissioner

REPORT OF THE COMMISSION ON PUBLIC HEALTH

The Commission on Public Health is composed of the following: Mental Health Committee, Committee on the Medical Aspects of Sports, Occupational Medicine Committee, Advisory Committee to the Easter Seal Society, Liaison Committee to the S. C. Department of Vocational Rehabilitation — Disability Determination Division, Committee on Primary Health Care of the SCMA and the Committee on Aging.

The Mental Health Committee continues to oppose legislation that would delete the requirement that the State Commissioner of Mental Health be a medical doctor with approved training and experience in psychiatry. Although the SCMA's opposition was largely responsible for its defeat in 1984, the bill has resurfaced once again this year. The committee continues its work on South Carolina Commitment Laws and will participate at the Risk Management Seminar at the Annual Meeting.

For the fourth consecutive year the Committee on the Medical Aspects of Sports has planned a Sports Medicine Workshop which will be held on April 26, 1985, in conjunction with the Annual Meeting. Governor Riley signed the Athletic Trainers' Act in June last year which has been a desirable goal of this committee and the SCMA. Mini-clinics for coaches and trainers locally continued to be a primary project for the committee collectively and individually in cooperation with county medical societies.

Quarterly meetings of the committee on Occupational Medicine were conducted during the past year. The most notable accomplishment was the updating of the schedule of fees for physicians

rendering services to Workman's Compensation patients. Comments on pending bills in the House and Senate relating to Workman's Compensation were reviewed and recommendations made to the SCMA's Legislative Committee. On two occasions during the year, the committee met with the Industrial Commission to discuss mutual problems.

At the time of this report, the Committee on Primary Health Care of the SCMA is considering action on two issues. These issues are: (1) Phase II of the Governor's Primary Health Care Task Force and (2) the Integrated Healthcare System Report relative to a statewide method of physician placement.

In February, the Medical Advisory Committee to the S. C. Department of Vocational Rehabilitation met with the Department senior staff. Rehabilitation programs for handicapped South Carolinians and the problems with maintaining certain services due to funding cutbacks were the principle items of discussion.

The Liaison Committee to the Disability Determination Division continues its efforts to assist the Division. Major interests are to educate physicians about the program and to help resolve problems being faced by physicians and their patients.

Since the purpose of this report is to highlight the work of the committees comprising the Commission on Public Health. I encourage you to read the complete committee reports contained in the handbook.

Respectfully submitted,
J. Sidney Fulmer, M.D.,
Commissioner

REPORT OF THE ALCOHOL, DRUG ABUSE AND IMPAIRED PHYSICIANS COMMITTEE

This committee has continued to offer its help to fellow physicians who are in trouble with alcohol, drugs or any other form of impairment. We can offer greater assistance to the doctors (and their families) if we receive referrals before the individual becomes involved with the Board of Medical Examiners or other legal entities.

The Impaired Physicians Committee of the SCMA has made tremendous progress in a difficult area since its activation. The committee has established trust, serving suffering colleagues with concern, care and support. At mid decade, the problem of impairment remains. However, the solutions to the problems are more readily available, and former methods have been replaced by hard data, scientific methods and established treatment modalities.

We have a four-fold responsibility to the medical consumer, the medical profession, to the impaired physician and to the family and colleagues of the physician patient. Fortunately these areas are nearly always complementary and concurrent with the board of Medical Examiners.

This year we have spoken to other organizations such as nurses, lawyers, dentists and even veterinarians who are starting up an impairment program. Additionally, we have spent considerable time and effort promoting our services to the county societies and auxiliaries as well as the hospital administrators.

Our state is but one in 50 in which doctors are trying to help doctors help each other. We are doing a good job once we get a referral. Unfortunately, we estimate we are working with only ten percent of those who need help.

President Ken Owens has the question in *The Journal* of the SCMA, "Am I My Brother's Keeper?" The answer, of course, must be "Yes!"

Respectfully submitted,
George M. Grimball, M.D.,
Chairman

Committee Members:

George M. Grimball, M.D., *Chairman*
Skottowe B. Fishburne, M.D.
Robert E. Livingston, M.D.
J. W. Taber, Jr., M.D.
James F. White, M.D.
William E. Fender, Jr., M.D.

C. Lide Williams, M.D.
Douglas F. Crane, M.D.
Stoney A. Abercrombie, M.D.
Frederic F. Adams, Jr., M.D.
Peter J. Botzis, M.D.
George Hughston, M.D.
Harold W. Moody, M.D.
John E. Gibbs, M.D.
Hugh V. Coleman, M.D.
M. E. Borgstedt, M.D.
William S. Hall, M.D.
Richard M. Taylor, M.D.
Alexander Hyde, M.D.
J. Rutherford Smith, M.D.
James F. Graham, M.D.
Roger Goetz, M.D.
Stuart Oppenheimer, M.D.
George Buxton, M.D.
Mrs. George M. Grimball (*Auxiliary*)
Mrs. George Buxton (*Auxiliary*)

REPORT OF THE JOINT COMMITTEE ON CARDIAC REHABILITATION

The Joint Committee on Cardiac Rehabilitation has been active this past year developing certification and recertification of cardiac rehabilitation programs.

The Committee has approved two types of certification, full and provisional. For the first round of certification, teams from North Carolina will be used to certify existing programs.

The major task has been developing the criteria which will be used to evaluate the programs. Much time and effort went into developing the criteria which were finally accepted by the Committee in November.

Respectfully submitted,
William Barnwell, M.D., *Chairman*

Committee Members:

William Barnwell, M.D., *Chairman*
Carl White, M.D.
Frederic G. Jones, M.D.
C. Warren Irvin, M.D.
Harry Allen, M.D.

REPORT OF THE CONSTITUTION AND BYLAWS COMMITTEE

Your Committee on Constitution and Bylaws along with SCMA staff with input from SCMA Council has worked very diligently on a new set of bylaws to go along with the tentatively approved (per the 1984 Session of the SCMA House of Delegates) SCMA constitution. The Constitution which covers two pages is attached to this report assuming that final approval will come in this session of the House of Delegates. The attached version of the SCMA bylaws could be approved as amended. (*Attachments will appear in Delegates' Handbooks.*)

The Bylaws which have been developed "match" the new constitution, and we have largely developed a decimalization system for the new bylaws. In undertaking to write the new bylaws we took much of the language that was in the old SCMA Constitution and moved it to the bylaws section.

In performing the task of writing the new bylaws the directions issued by the House of Delegates in 1984 have been, of course, followed. These included the instructions to incorporate a

hospital medical staff section, incorporate a confidentiality provision for peer review and other more incidental changes or additions.

A specific section of the proposed bylaws makes reference to "criteria for leadership positions and duties and responsibility of officers (SCMA)". These criteria will be attached to the SCMA Constitution and Bylaws and are attached to this report which includes the entire SCMA Constitution and Bylaws. I will note that these criteria are for guidelines only and are not legally binding.

Please give these documents your studied attention for they represent a year's work for this committee.

Respectfully submitted,
Jack Evans, M.D., Chairman

Committee Members:

Clarence Flanigan, M.D.

Charles R. Duncan, Jr., M.D.

John C. Hawk, Jr., M.D.

E. Arthur Dreskin, M.D.

Lawson Stoneburner, M.D.

Walter J. Roberts, Jr., M.D.

REPORT OF THE LEGISLATIVE ACTIVITIES COMMITTEE

The SCMA Committee on Legislative Activities has met once (November 4, 1984) since I have been on board as Chairman of this Committee. Our major focus since my assuming this position has been to (1) gear up for 1985-86 legislative session and educate our membership on the Committee on the issues that are taking shape — especially tort reform legislation, insurance equality, mental health legislation and other proposals; (2) plan for another legislative workshop; and (3) continue the upgrading of the SCMA Scapell program.

The SCMA is experiencing one of the busiest years ever at the South Carolina Legislature. Our tort reform package seems to be off and running and I will simply refer you to the report of the committee on Professional Liability for details.

The so called "insurance equality" legislation or legislation that would mandate that health insurance policies pay for the services of psychologists, chiropractors, optometrists, etc. is a very big issue at the State House this year. At least six

bills have been introduced as of the writing of this report. The non-MD professionals precipitating the introduction and consideration of this legislation simply want to get more of the health insurance dollar and they have lobbied the legislature heavily in this effort. The SCMA has formed coalitions with the business community (including the State Chamber of Commerce) and the insurance industry, the hospitals and others to ward off mandated health benefits legislation. As South Carolina is one of only about ten states which has *not* passed legislation of this ilk it becomes increasingly difficult for us to keep defeating these bills. Politically astute doctors who have the time should become educated in this issue so that they may help us in contacting legislative leaders on this issue.

Legislation that would delete the current statutory requirement of having an MD as the commissioner of the Department of Mental Health is again an issue in the 1985-86 legislature. Many leaders in the General Assembly continue to feel

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that physicians cannot be good administrators and are pushing hard to delete this longstanding statutory requirement. The physician community seems to be the sole entity left who seems aware of the damage that can be done in the state's mental health institutions should this legislation pass.

As this report was being written the living will legislation or the so called death with dignity bill had passed the House of Representatives and is now being considered in the State Senate where its changes are considered good as regards passage into law. SCMA has for over eight years supported legislation to allow a person with a terminal illness to stipulate that no extraordinary efforts will be made to prolong his/her life in such circumstances. It is our feeling that this new law would clear up much confusion in the legal/medical community as to what could be done in these type circumstances.

Cost containment and care for the indigent is a big issue at the State House this year. One bill has been introduced to simply set up a cost containment commission to monitor the cost of health care. SCMA is opposed to this concept. We are instead supporting "in principle" the so called McDonald Legislation (named after former Senator Heyward E. McDonald as a principle proponent) which would provide a mechanism to fund indigent care in the state's hospital system. Monies would be raised through fifteen million dollars in state funds along with a \$7.5 million assessment against the participating hospitals. These monies would be matched against federal funds to total up a ninety million dollar fund to pay for indigent needs in the state. A large proportion would go to bring over 40,000 people onto the AFDC rolls and a very large proportion would go to actual funding of indigent care in the hospitals. We are very carefully monitoring this legislation which has also provisions to provide alternate delivery systems in the state and additionally to provide for "cost containment."

There are many, many other issues that we are dealing with in the legislative arena but we feel that time does not permit us to catalog all of them in this particular report. I must urge that each physician in South Carolina read the SCMA Legislative Update which will provide you with up-to-date information on the developments in South Carolina Legislature, especially as they impact on physicians in the health care community.

A subcommittee has been created from the Legislative committee to look into the possibility of organizing and putting on a legislative workshop or seminar — similar to the one that was held in Hilton Head in early 1984. That earlier seminar was underwritten by Smith, Kline and French Laboratories and was attended by approximately 200 MDs and spouses. Also present were 18-20 faculty members made up of legislative staff of legislators and agency types. Since there appears to be less inclination by this particular drug company and other drug companies to underwrite programs of this nature the subcommittee will be looking into alternate methods to fund and otherwise undertake to put on another high caliber program of this nature in the near future.

The SCMA SCAPELL (South Carolina Auxiliary-Physician Education Legislative Liaison) system continues to see a general reorganization. The district concept for the SCAPELL Chairman has been shelved and we now have simply a SCAPELL Chairman in *each* county of the state. This is a concept which we think will work better and importantly can be more easily managed at Headquarters by your Chairman, the President-Elect of SCMA and the SCMA staff. Beginning December of last year we undertook to notify each of the newly appointed SCAPELL Chairmen of the need to enlarge our list of contacts for the many Legislators in the South Carolina General Assembly. Currently we are beginning to hear back from the SCAPELL Chairmen with their thoughts and additional doctors who can come in and contact their local legislator on issues of importance to the medical community. At this point I must urge all doctors reading this report to let SCMA staff know if *you* know a Legislator, can communicate with one or more Legislators, to then list yourself or allow yourself to be listed as a "SCAPELL contact."

Frank Rogers, our Lobbyist for the past seven years has left us to take a similar position in another state. His leaving us was a loss but we are at the same time happy to report that the legislative program is continuing to see the benefits of a general revamping and upgrading that began in mid to late 1984. Bill Mahon, the organization's Executive Vice President is becoming a familiar face at the legislature where he is functioning as a fulltime lobbyist. Additionally, Ron Scott, a prominent Columbia attorney and former aide to sev-

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eral Senate committees is serving as an advisor and legislative liaison for SCMA. The clerical administrative staff has also been reorganized to provide greater assistance to the legislative program. Along with extra staff the new word processors have been added to get letters out quickly to the SCAPELL program.

Susan Nickles has joined SCMA to take over Frank's duties as our governmental representative. She comes from the Columbia Chamber of Commerce where she was Director of Governmental Affairs. We hope all politically aware doctors will welcome Susie and cooperate with her in making SCMA's Legislative/SCAPELL Program as effective as it can be.

SCMA's Doctor of the Day Program at the State House continues to function in a most effective manner with excellent volunteer physicians serving on each legislative day and continuing to receive legislative plaudits. I should mention that we have two outstanding nurses who "man" the Doctor of the Day room during each legislative day; their names are Pat Kirkland, RN and Hazel Johnson, RN. Additionally, Strother Pope, M.D., Chairman of our Doctor of the Day Subcommittee continues to give medical oversight and provide good liaison with legislative leaders who fund the necessary supply needs for the program. Many of the drugs utilized in the program are sent to us gratis by several of the prominent pharmaceutical houses.

The Doctor of the Day Program continues to give SCMA and physicians in general excellent exposure and visibility at the State House. A visit there as "Doctor of the Day" can be very enlightening and entertaining; I must urge all physicians who can afford to take one day off during the year to do so for this worthwhile cause. Please contact Donna Houston at SCMA Headquarters who is the staff person for the Program. She will be glad to sign you up for your day at the Legislature.

The South Carolina Legislature has seen many changes in leadership over the past year due to

both the general and primary elections and organizational elections within the legislative/parliamentary process. It is a must that we become active and get to know the leadership and work with them to see that the public receives the best health care possible.

Respectfully submitted,
Frank W. Young, M.D., Chairman

Committee Members:

G. B. Hodge, M.D.
Roy E. Nickles, M.D.
William L. Meehan, M.D.
Kenneth Nunnery, M.D.
Hunter R. Stokes, M.D.
James E. Kay, M.D.
M. S. Funderburk, M.D.
Mrs. J. Ray Ivester
Frederick J. McElveen, M.D.
Clarence J. Edens, M.D.
B. E. Nicholson, M.D.
Robert R. Taylor, Jr., M.D.
William E. Marks, M.D.
Donald Jackson, M.D.
David J. Gatti, M.D.
Fletcher C. Derrick, Jr., M.D.
Everett L. Dargan, M.D.
O. Marion Burton, M.D.
Halsted M. Stone, M.D.
James B. Page, M.D.
H. Cooper Black, M.D.
Stephen Imbeau, M.D.
John C. Beard, Jr., M.D.
Raymond Grubbs, M.D.
Mrs. Warren Y. Adkins
Jay Hammett, M.D.
G. P. Hillen, M.D.
R. E. Livingston, Jr., M.D.
William B. Jones, M.D.
Gaines Hammond, M.D.
Julius Earle, M.D.
Clarence Flanigan, M.D.
Mrs. William L. Meehan

REPORT OF THE LIAISON COMMITTEE TO S. C. VOCATIONAL REHABILITATION DEPARTMENT — DISABILITY DETERMINATION DIVISION

During the past year, the Liaison Committee to the South Carolina Department of Vocational Rehabilitation Disability Determination Division's activities continues to center on educating physicians about Social Security, disability determination and their role in the program.

The committee met during the summer months to discuss changes in the disability program. One major change in the program is that the moratorium on the processing of continuing disability claims involving psychotic disorders and other types of mental impairments has been lifted. The magnitude that this will have on physicians and claimants (patients) remains to be seen. Clarification is expected in the near future from the Disability Determination Division. The methodology of adjudicating certain types of claims, particularly psychiatric claims, has undergone revision over the past year. The expectations are that this will result in more uniformity and rapidity in adjudication of current claims. Clarification by the Disability Division of the overall effect of these changes on physicians and patients will be hopefully forthcoming.

In an effort to explain the role of the physician in the disability determination process, the Disability Determination Division and the committee viewed a continuing education film produced by the Disability Division this past year. The committee's opinion of the film was positive. The film would be an adjunct to the physicians of South Carolina aiding and clarifying some of the

misunderstanding and misconceptions that physicians have regarding the adjudication of Social Security disability claims. We would recommend each society across the state view this particular film.

The committee also reviewed with the Disability Determination Division several psychiatric claims that had encountered difficulty in processing. The problem in each case was secondary to the reporting physician not being aware of the type report and documentation required to adjudicate these claims. An article clarifying these problems hopefully will be published shortly.

We are confident that through the joint efforts of the Division and the committee, the disability review process can be improved and many of the program's past problems can be eliminated.

Respectfully submitted,

Belton D. Caughman, M.D., Chairman

Committee Members:

Belton D. Caughman, M.D.

Carlyle Barfield, Jr., M.D.

Jeffrey G. Lawson, M.D.

Donald H. McClure, M.D.

Warren White, M.D.

Daggett O. Royals, M.D.

Henry C. Martin, M.D.

Richard E. Ulmer, M.D.

Henry Martin, Jr., M.D.

Fred H. Fellers, M.D.

Lee C. Dimery, M.D.

REPORT OF THE MEDICAL ADVISORY COMMITTEE TO THE SOUTH CAROLINA DEPARTMENT OF VOCATIONAL REHABILITATION

The South Carolina Medical Association Advisory Committee to the Vocational Rehabilitation Agency met Wednesday, February 20, 1985, at the Sheraton, Columbia, South Carolina. Dr. Ben N. Miller, Chairman, presided. Members of the committee present were: Dr. Frank Axson, Seneca; Dr. James R. Buehler, Iva; Dr. Rembert O. Burgess, Spartanburg; Dr. Malcolm U. Dantz-

ler, Columbia, representing DHEC; Dr. Robert E. Hartvigsen, Columbia; Dr. Edward E. Kimbrough, Columbia; Dr. Woodrow W. Long, Greenville; Dr. John P. Taylor, Greenville; Dr. Braxton B. Wannamaker, Charleston; Mr. William L. Watson, Columbia; and Dr. Alex Brown, Columbia, representing the Dental Association.

The Vocational Rehabilitation Agency was rep-

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resented by Mr. Joe S. Dusenbury, Commissioner; Dr. Robert E. Brabham, Assistant Commissioner, Client Services; Dr. Keels F. Baker, Medical Consultant, Disability Determination Division, Charleston; Dr. Lee C. Dimery, Physician, Disability Determination Division, Greenville; Mr. Thomas C. Hadwin, Client Services Supervisor; Mr. Frank G. Honea, Regional Supervisor, Disability Determination Division, Columbia; Mr. Walter J. House, Client Services Consultant; Mr. P. Charles LaRosa, Assistant to Commissioner; Mr. L. Wayne Nance, Quality Assurance Analyst, Disability Determination Division, Columbia; Dr. E. H. Prescott, Physician, Disability Determination Division, Columbia; Mr. Vince Rhodes, Client Services Supervisor; Mr. T. E. Ringer, Assistant Commissioner, Administrative Services; Mr. Raynold Stoudemayer, Client Services Supervisor; Mr. Richard A. Vandiver, Director Disability Determination Division; Dr. H. L. Laffitte, Allendale, Vice Chairman, Agency Board and Mr. Joseph V. Staiano, SSA, Atlanta, Georgia.

Dr. Ben Miller welcomed the committee members and expressed his appreciation for their presence. Dr. Miller reminded the group that when rehabilitation began providing major medical services, a medical advisory committee was appointed by the Vocational Rehabilitation Department. It was also felt that it would be desirable to have the committee become a part of the committee system of the South Carolina Medical Association. This was done with the proviso that the Vocational Rehabilitation Department would be allowed to nominate the persons to serve on the committee.

Mr. Joe Dusenbury, Commissioner, was presented and he stated that it was extremely important that the committee members take part and represent the Department with the Medical Association. Mr. Dusenbury stated that periodically the Department has problems that need input from the committee members. He also pointed out that funding for Vocational Rehabilitation is now more stable than it has been for a number of years.

Mr. Richard Vandiver, Director of Disability Determination Division, was presented to bring the committee up-to-date on some of the issues from the last meeting and some of the concerns that Congress had about the Disability program. There has been much media attention about people being taken off the Disability rolls incorrectly

and the concern was how the Disability program was being handled and what criteria were being used. In early 1984, Congress, the President and Administrators of the program felt it was time to stop and bring things into focus. This led to the Disability Benefits Reform Act of 1984. This law was directed at three broad areas of the program, the actual disability decision making process itself, the work incentive provisions and the program administration area; and, some of the technical concerns were the way the program was being coordinated by the state and federal government. Mr. Vandiver pointed out that there are six major areas in the decision making process. The first is the standard of review that was used when determining whether or not someone is still entitled to disability benefits. The handling of medical impairment claims was an issue where many felt that the methods were not in tune with the needs of the people. Evaluation of pain was looked at and Congress insisted that a new look be taken at what is being done with this difficult issue. Congress also required that the types of medical evidence being used in the decision making process be looked into. The process for purchasing examinations needed to be checked to see if there was enough background information on the individual before a decision to purchase an examination could be determined. Part of the 1980 Legislation said there was to be a review process that will look at everyone on the rolls periodically to see if they are still disabled. This process was implemented in March, 1981. One of the major concerns that came up right away was when the body of evidence said an individual was disabled and ten years later this same evidence says the individual is not disabled. The methods of evaluating clients have changed somewhat, the medical criteria have changed and this led to making decisions to take individuals off the rolls with what appeared to be the same evidence used in putting them on. Congress then required that consideration be given as to whether or not a person is medically improved before they are taken off the roll. There is a medical improvement standard that is being used in determining whether someone is to be taken from the rolls. Medical improvement standard is not the only way that a person's benefits can be stopped. There are some major exceptions that can be used instead of the medical improvement. (1) Advances in medical technology, (2) Vocational technology,

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(3) Fraud, (4) Errors on the face of the evidence. Issues of this type will be used extensively. This provision will go into effect in June or July. No benefits have been terminated, based on disability, since December, 1983. Congress has implemented an appeals process that allows a person to appeal the adverse decision. The problem the Disability Division had was to determine what work related mental functions are, and how to better determine how those functions are limited by mental impairments and how to accurately identify what limitations a person might have. Psychiatric consultants have been added to the staff to assist with this problem. People who had a decision made on their claim between March, 1981 and October, 1984 will have an opportunity to have their case reviewed again using the new criteria. The individuals who had appeals pending in October, 1984, or had a decision made then or later, will automatically get a notice from SSA stating the new changes and asking if they want their claim reconsidered. There will be several thousand people who will be offered a chance to have their claims reviewed. Congress has made it clear that the person's ability to work must be foremost in such decisions. About 600 individuals in South Carolina will have their claims looked at from the vocational standpoint as well as a medical standpoint.

There is a task force being formed by SSA to draw on the resources of the medical associations and medical professions throughout the country to get their advice on the best way to evaluate the impact of pain. SSA says there has to be identifiable physiological abnormality that can be proven. If this is not there, then pain cannot be considered as a limiting factor. Congress has upheld this position, but it was not felt they had gone far enough and more advice was needed as to how this issue should be dealt with. The Task Force is studying this now and cases will be earmarked that have a significant pain component for possible reevaluation.

Congress has stated that before any medical information is purchased all available evidence must be secured from the treatment sources for the last 12 months, then a decision can be made concerning the purchase of additional medical examinations. This will increase greatly the number of requests that are sent to the medical profession and will increase the number of examinations required.

Congress has stated that qualified psychiatrists and psychologists are needed to participate in evaluating the mental impairment claims. Congress is going to insist that there be a longitudinal historical prospective of the individual before a decision can be made based on mental impairment.

Dr. Brabham, Assistant Commissioner, was introduced and he stated that with increased industrialization and more and more programs that are coming up with group insurance for their employees there was a decrease in the number of persons for whom the medical payment issue was a problem. Vocational Rehabilitation had become an insurance care program for the working poor. Congress was saying very clearly that Vocational Rehabilitation was to be a "vocational" program. This does not mean that if during the rehabilitation process there is still a need for medical services they cannot be provided. If this will culminate in Vocational Rehabilitation getting that person a job, it will be provided. It became a matter of ethical honesty that if clients do not need something that Vocational Rehabilitation staff can provide, then credit should not be taken for getting them a job. If clients need the total package of services, including the general medical, medical treatment, job retraining, some job reengineering, intervention with the employer, this will be provided. Job placement is Vocational Rehabilitation's claim to fame, this is what Rehabilitation is better at than any other agency. It was pointed out that Congress never intended for Vocational Rehabilitation to be a state/federal version of Blue Cross/Blue Shield. The General Assembly, Congress and tax payers do not want to pay state employees to take credit for some insignificant services, but would be willing to pay them to put someone back to work. As a result, this has been the focus of the Department. Rehabilitation employees have to provide services that are important and make a difference in the outcome of the case. In spite of the economy and some hard times in recent years, Vocational Rehabilitation has been putting back into competitive employment approximately 8,000 people per year. We are moving toward a training, job restructuring, job reengineering type of focus after the medical profession has done their part of the medical process. There is success — Example: Ninety percent of the people who come to Vocational Rehabilitation had no income at referral and many

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others were in jeopardy of being fired. After rehabilitation they are working. It cost approximately \$3,000 to put someone back to work in this state. In less than four years they will repay the cost of their rehabilitation in taxes. Rehabilitation is paying a twenty-five percent return on investments. Vocational Rehabilitation is working for clients and taxpayers.

Full discussion was held by the members of the committee with questions directed to the staff and those present stated they felt this was a very informative meeting.

There being no further business or discussion, the meeting concluded with dinner, provided by the Department.

Respectfully submitted,
Ben N. Miller, Chairman

Committee Members:

Ben N. Miller, M.D., Chairman
Randolph D. Smoak, Jr., M.D.
Frank Axson, M.D.
Braxton B. Wannamaker, M.D.
Donald Shelley, M.D.
Robert J. McCardle, M.D.
Edward E. Kimbrough, M.D.
Robert F. Hartvigsen, M.D.
John P. Taylor, M.D.
Kenneth J. Bonniface, M.D.
James R. Buehler, M.D.
Rembert O. Burgess, M.D.
Woodrow W. Long, Jr., M.D.

REPORT OF THE MEDIATION COMMITTEE

The Mediation Committee to the South Carolina Medical Association has not found it necessary to meet during the past twelve months. This is an indication of the growing number of component medical societies with very efficient and active Grievance Committees, who are capably handling complaints that originate within their jurisdiction. Currently, 26 out of a total of 40 medical societies have active grievance committees.

Fifteen complaints came to our Committee last year. All were referred to the respective component societies. Eleven of the complaints were satisfied by the component society; three of them were

resolved and one was referred back to our Committee.

Respectfully submitted,
J. Capers Hiott, M.D., Chairman

Committee Members:

J. Capers Hiott, M.D., Chairman
Robert F. Marion, Jr., M.D.
William L. Meehan, M.D.
John R. Hunt, M.D.
Max A. Culp, M.D.
W. Rion Dixon, M.D.
E. Arden Weathers, M.D.
G. Preston Edwards, M.D.

REPORT OF THE MEDICAL ASPECTS OF SPORTS COMMITTEE

The Medical Aspects of Sports continues to be a popular and highly visible program of the South Carolina Medical Association.

Letters from the committee were sent to all county medical society presidents urging them to sponsor mini-clinics locally for coaches and trainers. Although the response was not overwhelming, some medical societies did sponsor sports medicine workshops which were both successful and meaningful in the respective communities. The Committee on the Medical Aspects of Sports is available to any county medical society or group planning and conducting such clinics.

On June 19, 1984, Governor Riley approved the Athletic Trainer's Act of South Carolina which provides for the certification of qualified athletic trainers which will result in improved training services with physical modalities for rehabilitation and treatment.

The 1985 SCMA Annual Meeting will include a three and one-half hour program with speakers and topics to attract physicians, trainers and coaches. Headlining the program is the revered Coach, Cally Gault, who served as head coach of Presbyterian College for 25 years and is currently Athletic Director of that institution. Other presentations include: "Facial Injuries in Athletics," "Dermatological Problems with Athletics," "Facts and Fiction in Nutrition," "Guidelines for

Returning the Athlete to Participation," and a "Demonstration on Taping, Braces, Equipment and Heat Station."

The Committee on the Medical Aspects of Sports has requested that the size of the committee be increased to provide more assistance for mini-clinics throughout the state in 1985. Emphasis in 1985 will be on county society sponsorship of mini-clinics for high school coaches and trainers.

Respectfully submitted,

Roland M. Knight, M.D., Chairman

Committee Members:

Roland M. Knight, M.D., Chairman

W. Ray Henderson, Jr., M.D.

Robert A. Martin, M.D.

William E. Gregory, Jr., M.D.

F. E. Reed, M.D.

David J. Gatti, M.D.

Samuel T. Haddock, M.D.

Al Dawson, M.D.

J. S. Seastrunk, M.D.

C. Warren Irvin, Jr., M.D.

Robert Belding, M.D.

Joe N. Jarrett, Jr., M.D.

James R. Barham, Jr., M.D.

Howard N. Poston, Jr., M.D.

Kenneth Jago (Student)

Frederick Hoover (Consultant)

REPORT OF THE MENTAL HEALTH COMMITTEE

The Mental Health Committee has been active this year dealing with matters of concern to our profession. Our activities have centered on legislative affairs, physician-patient confidentiality, S. C. Commitment Laws and the problems of physicians and their families. As requested by physicians from Charleston, the committee reviewed current commitment procedures that require Probate courts to use only state employed physicians to perform examinations for State Mental Hospital commitments. The committee reviewed the State's Commitment Laws and testified before a subcommittee of the Legislative-Governor's Committee on Mental Health and Mental Retardation asking for relief from this requirement. At this same subcommittee meeting, additional recommendations were given that

would assure quality care for our patients without severely restricting the ability of the Department of Mental Health to carry out its mission.

The committee continues to oppose legislation that would delete the requirement that the State Commissioner of Mental Health be a medical doctor with approved training and experience in psychiatry. The SCMA has testified in opposition to this bill and was largely responsible for its defeat during 1984.

At the Annual Meeting in 1984, the Mental Health Committee joined with the Committee on Alcohol and Drug Abuse and Impaired Physicians and presented an afternoon workshop on prevention of problems in physicians and their families. Speakers addressed the issues of stress, drugs and alcohol and then break out sessions were held for

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more in-depth discussions with the participants.

This year, the committee will participate in a Risk Management Seminar to discuss the emotional impact of malpractice on the physician and his family.

Respectfully submitted,

Richard K. Harding, M.D., Chairman

Committee Members:

Richard K. Harding, M.D., Chairman

R. Bruce Ford, M.D.

M. E. Borgstedt, M.D.

Roy B. Suber, M.D.

Melton R. Stuckey, M.D.

William H. Crigler, M.D.

John G. Black, M.D.

Samuel R. Shannon, M.D.

David C. Jacobs, M.D.

Robert M. Callis, M.D.

Dennis Cohen, M.D.

Douglas Crane, M.D.

Deborah D. Leverette, M.D.

REPORT OF THE PERINATAL AND MATERNAL HEALTH COMMITTEE

The Perinatal and Maternal Health Committee has continued to investigate causes of maternal mortalities in spite of poor cooperation from some physicians! Although work continues on protocols for investigating infant mortalities, this has not yet been completed.

Considerable time and effort, not only by the Perinatal and Maternal Health Committee, but also by pediatricians, family practitioners and obstetricians has been devoted during the year to the medical criteria for determining "high risk" under the proposed waiver to the Medically Needy Program.

This matter was reviewed by the SCMA Council on several occasions before the revised medical criteria for the definition of "high risk" was approved and endorsed.

At its July meeting the committee considered and disapproved a Palmetto Lowcountry Health System Agency, Inc., Alternate Birth Center Study. Subsequently, Council concurred with the committee's recommendation to disapprove.

Other areas in which the Perinatal and Maternal Health Committee has been involved include

the opposition to free standing birthing centers, the hoped for repeal of the Lay Midwifery legislation and plans to study live and dead births of lay midwife deliveries. It has also gone on record as opposing a section of the Governor's Perinatal Plan of Action which it considered to interfere with the freedom of choice with private sector patients.

Because of adverse weather conditions in parts of the state, the January meeting was postponed, but the committee expects to have one additional meeting before the SCMA Annual Meeting.

Respectfully submitted,

Tom L. Austin, M.D., Co-Chairman

Hal R. Rubel, M.D., Co-Chairman

Committee Members:

Tom L. Austin, M.D., Co-Chairman

Hal R. Rubel, M.D., Co-Chairman

Henry C. Heins, Jr., M.D.

John Hooker, M.D.

Giles M. Schanen, M.D.

Clarence M. Easley, M.D.

F. M. Lemmon, Jr., M.D.

David R. Chapman, M.D.

Thomas W. Hepfer, M.D.

Jerome Degen, M.D.

William E. Fender, Jr., M.D.

Robert Callis, M.D.

E. J. Dickert, M.D.

Larry S. Atkinson, M.D.

Halsted M. Stone, M.D.

Rufus H. Cain, Jr., M.D.

Clarence E. Coker, Jr., M.D.

Robert E. Foster, M.D.

Boyd L. Hames, M.D.

Dilip M. Purhoit, M.D.

John M. Moore, M.D.

Gerald J. Ferlauto, M.D.

Hal C. Anderson, M.D.

David C. McLean, M.D.

Charles Propst, M.D.

B. C. Pendarvis, Jr., M.D.

Sami B. Elhassani, M.D.

Jack W. Rheney, M.D.

Salvatore Rini, M.D.

Sharon Ellis, M.D.

Larry B. White, M.D.

Harold D. Gabel, M.D.

REPORT OF THE COMMITTEE ON PRIMARY HEALTH CARE

The Committee on Primary Health Care made several recommendations to the SCMA Council, all of which were approved. Our recommendations were that:

(1) SCMA lobby to legislate certification as a method of regulating organizations engaged in "clinic" directed weight loss activities and that the certification be administered by DHEC.

(2) Public health education programs be developed for promotion in schools and in the media to inform South Carolinians about weight loss and proper nutrition, and that public high school curriculum changes should reflect this educational effort.

(3) SCMA endorse the concept and sponsor CME for practicing physicians regarding nutrition and that efforts be made to alter curriculae in the medical schools to emphasize physiologic consequences of improper nutritive practices.

The committee also concentrated its efforts on the development of a unified, coordinated system for accurately and appropriately determining physician shortage areas in South Carolina. The committee has previously been given the recommendation from the SCMA House of Delegates to pursue the development of an active recruitment program for medically underserved areas through a joint effort with the South Carolina Department of Health and Environmental Control. Prior efforts to develop a coordinated program with DHEC and the Consortium of Community Hospitals had failed. Already the Consortium has developed and instituted a new program to serve as a clearing house for available physicians, in fact opportunities. The Committee on Primary Health Care felt that no unified system was currently present and certainly no system that adequately addressed the myriad of issues regarding physician placement. As they currently exist, the different methodologies that are in place today make little regard of the practicing physician and the impact that some of the existing medical supply programs in recruitment programs would have on such physicians. This is where our committee has taken issue and concern. Consequently, the committee received approval from Council to develop a proposal as to how we could develop a methodology that would take into account all of the many factors necessary for placing physicians

properly. It was of concern to place these physicians properly in the areas where physicians already practice. Integrated Health Care Systems has contracted to create such a report.

Although too lengthy to be included here, the report has received approval from our committee. The Primary Health Care Committee is currently forwarding the report to Council for their review of the issue and the generated proposal. If the document is approved by Council, there still will need to be some plan developed to coordinate DHEC, the Consortium, SCMA and other programs in the use of this new method of determining health manpower shortage areas.

In all, the Primary Health Care committee finds itself currently addressing this singular issue. We appreciate the opportunity of serving SCMA and the physicians of South Carolina.

Respectfully submitted,
Milton D. Sarlin, M.D., Chairman

Committee Members:

Milton D. Sarlin, M.D., Chairman

H. G. Royal, Jr., M.D.

John Dieter, Jr., M.D.

Robert D. Harper, M.D.

Herbert A. Moskow, M.D.

James R. Barham, Jr., M.D.

S. Perry Davis, M.D.

REPORT OF THE PROFESSIONAL LIABILITY COMMITTEE

The Professional Liability Committee of the South Carolina Medical Association continues to work for your interest by keeping abreast of tort reform measures and professional liability issues locally and on the national level. In addition, it continues to assist physicians who have become victims of malpractice litigations. A subcommittee was developed to implement the SCMA/JUA Physicians' Risk Management Program which has been funded now for the third year and currently has the support of over 1,500 physicians who have volunteered their time and expertise for claims review, deposition, expert witness testimony and to provide moral support to fellow colleagues

COMMITTEE REPORTS

involved in medical liability suits.

The Risk Management Program is now in the second year of publishing the *Physicians' Risk Management Bulletin*. This publication is an excellent commentary for the physician community. It has pertinent guest articles, furnishes data on claims and law suits made against physicians in South Carolina, and gives a broad array of new developments in this area. The program has now had two statewide Risk Management Seminars, the latest one being held February 20 in Columbia on the subject of "Malpractice Prophylaxis." In addition, several regional and county seminars have been held and the committee is available to do this upon request. We should also note that many outstanding articles have been written for the *Physicians' Risk Management Bulletin* by several prominent attorneys in South Carolina.

Last year, members of a special subcommittee (Task Force on Medical Liability) on tort reform met with several well-known defense oriented attorneys in South Carolina to formulate SCMA's tort reform package for 1985-1986. The goal has been accomplished. Legislation has been drafted along with the necessary explanations and arguments. A meeting was held with a statewide business coalition group in Columbia on February 13. At that time the coalitions present agreed to support and facilitate the introduction of separate tort reform measures formulated by SCMA. These proposed measures are being distributed to the membership by the SCMA Legislative Committee and are available to any of you upon request. By the time this report reaches you, some, if not all, of these tort reform measures should have been introduced in the State Legislature. We are cautiously optimistic that these proposed law changes will be enacted into the statutes. If so, it will rectify many unfair circumstances regarding physician malpractice liability and we feel will benefit the citizens of South Carolina in the long run. We want and need support from each of you in this effort.

I have enjoyed my tenure as Chairman of this committee and I am above all impressed with the

calibre of people working with us on this committee and their concern for both the physicians in South Carolina and health care in general. I appreciate the cooperation of the Board of Directors of the Joint Underwriters' Association and particularly, the support of Mr. Cal Stewart, Manager of the JUA.

Respectfully submitted,
Euta M. Colvin, M.D., Chairman

Committee Members:

Euta M. Colvin, M.D., Chairman
Boyce M. Lawton, M.D.
Donald G. Kilgore, Jr., M.D.
J. Frank Biggers, III, M.D.
Bartolo M. Barone, M.D.
John R. Hunt, M.D.
O. Marion Burton, M.D.
William F. Fairey, M.D.
Roland L. Skinner, Jr., M.D.
William F. James, Jr., M.D.
B. Daniel Paysinger, M.D.
John C. Hawk, III, M.D.
J. D. Ashmore, Jr., M.D.

Subcommittee on Risk Management Members:

Euta M. Colvin, M.D., Chairman
B. Daniel Paysinger, M.D.
Roland L. Skinner, Jr., M.D.
John R. Hunt, M.D.
Bartolo M. Barone, M.D.

Subcommittee: Task Force on Medical Liability Members:

J. D. Ashmore, Jr., M.D., Chairman
B. Daniel Paysinger, M.D.
Donald G. Kilgore, Jr., M.D.
Bartolo M. Barone, M.D.
William F. James, Jr., M.D.
Robert A. Laughlin, M.D.
John R. Hunt, M.D.
R. Randolph Bradham, M.D.
Charles E. Corley, III, M.D.
Herbert E. Niestat, M.D.
Roland L. Skinner, Jr., M.D.
Salvatore A. Rini, M.D.

REPORT OF THE SCMA/SCNA JOINT LIAISON COMMITTEE

The SCMA/SCNA Joint Liaison Committee has been active this year having met twice up to the time of writing this report, and with a future meeting planned. The physician participation in this committee has been very poor.

The major accomplishment of the Committee was to exchange information on the Risk Management and Impaired Physicians/Nurses programs of the two associations. A special thanks to Drs. Euta Colvin and George Grimball for excellent presentation to the Committee.

Respectfully submitted,

James M. Lindsey, M.D., Chairman

SCMA Committee Members:

James M. Lindsey, M.D., Chairman

Lewis Reese, M.D.

Charles Crews, M.D.

W. G. Rhea, Jr., M.D.

George Duncan, M.D.

Stanmore Reed, M.D.

REPORT OF THE TASK FORCE ON ALTERNATE DELIVERY SYSTEMS

At the direction of the 1984 House of Delegates, this task force was appointed to study alternate delivery modes, to identify the resources required to develop them and to examine the feasibility of developing a statewide IPA, PPO or physician owned health insurance company.

It became readily apparent that a statewide approach to alternate health delivery was not feasible due to the broad range of attitudes and diversified needs of the physicians in this state. With the statewide approach ruled out, the Committee began to examine the current HMO activity in the state and the approaches being used.

The Committee studied various areas of the state. In Columbia where a group of physicians, under the auspices of the Columbia Medical Society, had contracted with Charter Medical of Minnesota to establish a HMO. Currently, over 300 physicians have joined, a staff director has been hired and marketing has begun. All of this was accomplished in an eight month period.

In Spartanburg the County Medical Society in cooperation with the South Carolina Medical Care Foundation, established a program to market private review to local industry as a cost containment measure. The program has begun offering a 10 percent discount on the physician charges, if the private review program is in place as well as a wellness program. In addition Spartanburg has opened negotiations with COMED of Ohio regarding establishment of an HMO.

Other HMO activity is underway in Florence, North Charleston, Greenville, and Anderson. All of this activity is not physician sponsored. Both Blue Cross, through Companion Health Care, and Provident, through Health Point are marketing PPO's or HMO's. Hospitals are also active in examining HMO arrangements and in the case of the HCA hospital in North Charleston, they are negotiating a contract with the medical staff.

In addition to studying current activity, the Committee also looked at the various models that were being developed. A variety of approaches are being used. The closed panel HMO, which would limit patients to a single hospital and a limited set of doctors is typical where hospital-medical staff joint ventures are utilized. The Preferred Providers Organization is another model and it too limits the patient's choice. The Individual Practice Association which can take a number of forms appears to be the most popular. IPA's can be physician only, which in general would be physician owned and operated and could include consumers if a legal requirement needed to be fulfilled. Second, an IPA could be a physician/hospital joint venture and governance is shared by both parties in a mutually agreeable ratio. Third, an IPA with hospital, physician and insurance company sponsorship is another model that has developed. Each of these models are currently in place or under discussion in the state.

The Committee, after study, is submitting the following recommendations:

- 1) That organized medicine act immediately to form cost effective alternative health delivery systems and participate fully in the development of these systems.
- 2) In developing these alternative health delivery systems it should be recognized that each community is unique and that it is vital that professional help be obtained to assist in evaluating the community needs and which model would be most appropriate.

COMMITTEE REPORTS

3) Alternative health delivery systems should be under the direction and control of local physicians where possible.

4) In areas where adequate resources are not available to develop alternative systems, affiliation with larger areas should be considered.

In summary, the Committee concludes that the delivery system is changing due to pressures being exerted by the purchasers of health care. To be responsive to these pressures, continue to exercise control of the delivery system and maintain market share, the profession must respond with innovative approaches to health care delivery.

Respectfully submitted,

H. Earle Russell, Jr., M.D., Chairman

Task Force Members:

H. Earle Russell, Jr., M.D., Chairman

Jack L. Ratliff, M.D.

John W. Simmons, M.D.

W. McGill Woodward, M.D.

Edward C. Mattison, M.D.

John C. Rawl, M.D.

Harrison L. Peebles, M.D.

Richard C. Slocum, M.D.

Lloyd C. Miller, M.D.

Arthur Pedersen, M.D.

Jerry R. Powell, M.D.

REPORT OF THE PRESIDENT OF THE SOUTH MEDICAL BUILDING, INC.

The Medical Building, Inc., has undergone significant changes this year and it is my pleasure to report to you that these changes have been positive.

Last year this House approved selling our headquarters building in Columbia, and buying a new one on I-26. This transaction was accomplished in July and in January, we completed the remodeling and moved. Our financial projections, which we presented last year, proved to be very accurate and as a matter of fact the remodeling was accomplished at 10 percent less than we projected. We now occupy a fine headquarters building that is mortgage free.

Our data processing operations changed significantly this year as well. We have for the past five years provided data processing services to a number of PSRO's around the country. With the termination of the PSRO program, we were left without a market. As a result, we sold our IBM computer equipment and now are providing data services to the Foundation and the Association on

a contractual basis. Although we have just completed the transition and have no financial data that reflect the time potential, we are predicting that the Building Corporation will continue to be as profitable as always, even with reduced income. The net result is we own a \$500,000 piece of property, have \$100,000 plus interest in the bank and we are out of debt.

In summary, we feel the Building Corporation has had a great year, and we are optimistic about the future.

Respectfully submitted,

C. Tucker Weston, M.D., President

Board Members:

C. Tucker Weston, M.D., President

S. Perry Davis, M.D.

Harold E. Fleming, M.D.

J. Ernest Lathem, M.D.

Harrison L. Peebles, M.D.

Melton R. Stuckey, M.D.

REPORT OF THE SOUTH CAROLINA POLITICAL ACTION COMMITTEE

At the 1984 Annual Meeting of SOCPAC in Charleston, those members in attendance studied most of the 124 House Districts and most of the 46 Senate seats and made a preliminary budget on candidates to support from the information available at that time.

It proved to be a worthwhile venture and was quite helpful to the SOCPAC Board of Directors when the time for a decision arrived. Many things changed between April and November, but the framework established early in the year is an exercise which should be repeated every election year.

Members of the SOCPAC Board understand that "you can't please all of the people all the time," but the selection process is becoming more sophisticated and much more information is available to the Board to make candidate support decisions on the basis of facts and information rather than a *quid pro quo* system.

The answer to the question, "How did we do?" is, "Very Well!" Unfortunately, we lost some of our close friends in the legislature, but we look forward to working with new friends in helping them to understand the health care needs of the people of South Carolina.

Using actual figures, SOCPAC spent \$38,900 on a total of 89 candidates in the Primary and General Elections for a winning percentage of 85 percent. In October we exhausted our treasury, so we contributed an additional \$3,500 after the election to incumbents to whom we had promised help with their deficit campaigns. Our total financial contribution to South Carolina candidates for the House and Senate was \$42,400. (Money spent on deficit campaigns is not included in the percentage since they were already elected.)

On the Federal level, AMPAC contributed a total of \$35,500 to the six House races and the Senate campaign. These contributions were delivered to the various candidates by pac members in South Carolina. Our total monetary contribution in 1984 was \$77,900 from the medical profession collectively. This figure does not include individual campaign contributions by physicians and spouses, nor does it take into consideration the time, talent and energy of physician members and Auxilians in many campaigns throughout the state.

In 1985, the SOCPAC Board voted to make the sustaining membership the basic category of

membership for SOCPAC and AMPAC. This action was determined, in part, by other states who have reported great success in raising campaign funds. To date, this has proven to be a very worthwhile effort. Although the membership is slightly behind the comparable period last year, the amount of money available for candidate support has increased significantly.

We hope those who have not contributed to the pac movement thus far will reconsider and join in what we know will be our "best year ever."

As a matter of personal privilege, I wish to report to the House that I am honored to have been selected as a member of the AMPAC Board of Directors. Although my duties in this new capacity may take me from South Carolina for meetings, seminars and state pac functions, please be assured that my heart and soul will continue to be with my friends and colleagues in South Carolina.

Respectfully submitted,
Randolph D. Smoak, Jr., M.D.,
Chairman of the Board

Board Members:

Randolph D. Smoak, Jr., M.D., Chairman
William M. Hull, Jr., M.D.
Euta M. Colvin, M.D.
Mrs. J. R. Ivester
Mrs. Warren Adkins
Joseph Black, M.D.
Clay W. Exatt, M.D.
John C. Hawk, Jr., M.D.
Kenneth Warrick, M.D.
Frank W. Young, M.D.
C. Tucker Weston, M.D.
M. Stewart Funderburk, Jr., M.D.
Leonard W. Douglas, M.D.
William H. Hunter, M.D.
Kenneth N. Owens, M.D.
Terry M. Schroeder, M.D.
Mrs. William L. Meehan
Donald G. Kilgore, Jr., M.D.
Charles R. Duncan, Jr., M.D.
John W. Simmons, M.D.
Linwood G. Bradford, M.D.
Halsted M. Stone, M.D.
Robert E. Livingston, III, M.D.
Rufus H. Cain, M.D.
Thomas A. Whitaker, M.D.
Howard H. Poston, Jr., M.D.

REPORT OF THE S. C. MEDICAL CARE FOUNDATION

The Foundation became the first PRO (Peer Review Organization) in the nation on July 1, 1984. This is a true credit to the past record of peer review conducted by the physicians of South Carolina and to our plans for 1985 and 1986.

PRO's were specifically designed for the Medicare DRG payment system and hence the type of review performed by the Foundation has changed fundamentally. Admission and quality review are the two main foci of South Carolina Medical Care Foundation Medicare review while hospital UR Committees themselves monitor length of stay. The Foundation's Board of Directors is carefully charting the course of this new review with the intention of identifying ineffective and overly burdensome requirements and reporting these to DHHS and Congress. With this goal in mind, the Foundation Board wrote in criticism of the original physician attestation statement. Similarly the extensive, mandatory preadmission review program for Medicare has been and continues to be closely scrutinized with similar plans for input.

The PRO legislation was an important impetus in the expansion of Foundation private review. The PRO law was designed to facilitate the private sector's use of physician peer review in an effort to respond to the concern of these com-

panies over cost shifting from Medicare and Medicaid. The Foundation currently has contracts to perform concurrent inpatient review and billing audits with twenty-five (25) companies; this review is conducted in all hospitals in the state. The Spartanburg County Medical Society's contact with local industries in support of Foundation peer review has been an especially successful endeavor.

On behalf of the Board of Directors, I would like to extend my sincere appreciation to all those physicians who have supported our efforts with special thanks to those who have served as hospital Physician Advisors, Foundation Committee reviewers, and specialty consultants.

Respectfully submitted,
Leonard W. Douglas, M.D., President

Board Members:

Robert K. Moxon, M.D.
William H. Barnwell, II, M.D.
Halsted M. Stone, M.D.
Edward W. Catalano, M.D.
U. Hoyt Bodie, M.D.
William J. Goudelock, M.D.
William H. Hull, Jr., M.D.

REPORT OF THE SOUTH CAROLINA INSTITUTE FOR MEDICAL EDUCATION AND RESEARCH

The Board has met twice since the 1984 Annual Meeting. Two Board members have resigned and have been replaced by Susanne Black, M.D. and Rion Dixon, M.D.

Two significant events have taken place during the past year. First, the South Carolina Medical Association received a bequest from a deceased physician's estate with the funds to be used for education for a medical student in South Carolina. The Board was asked by Council to handle these funds and is in the process of determining how best to manage them and to select the qualified recipient.

Second, SCIMER has been relieved of all Continuing Medical Education activities, but will receive the benefit of any profits from the Update meetings held annually at Hilton Head.

SCIMER continues to receive memorial funds and we hope that this will continue and will

increase. The Board will appreciate suggestions from the membership with regard to the solicitation of funds and for appropriate activities of the use of these funds.

Respectfully submitted,
Euta M. Colvin, M.D., President

Board Members:

Euta M. Colvin, M.D., President
Randolph D. Smoak, Jr., M.D.
Kenneth N. Owens, M.D.
William H. Hunter, M.D.
D. Strother Pope, M.D.
J. Sidney Fulmer, M.D.
Ben N. Miller, M.D.
Susanne Black, M.D.
W. Rion Dixon, M.D.
Mrs. Leonard Douglas

REPORT OF THE MEMBERS' INSURANCE TRUST

The Board of Trustees of the South Carolina Medical Association's Members' Insurance Trust is pleased to render this report to the SCMA House of Delegates.

There have been several important changes in the Trust since our last report. During 1984, the Board of the Members' Insurance Trust solicited bids for the claims administration of the Trust. Both Blue Cross and Provident Life and Accident submitted bids and the contract was awarded to Provident. Effective February 15, 1985, this change was made and we feel confident that Provident will provide courteous, efficient and timely claims administration for the Trust.

Another change was the move to an age-banded premium structure, which lowered the cost of insurance to the majority of our subscribers. The purpose of this change was to provide for a more equitable assessment of premium costs based on actuarial projections of claim costs.

As of February 28, 1985, the total assets of the Trust were \$2,064,569.80. As of June 30, 1984, the

end of our last fiscal year, our fund balance was \$548,720.69, with an additional \$300,000.00 invested for incurred but not reported claims. The MIT is in excellent financial condition at this time. With this performance, it is felt we can keep member premiums at a minimum.

On behalf of the Members' Insurance Trust Board of Directors, I would encourage each and every member of the SCMA to participate in the Trust.

Thank you for your continued support.

Respectfully submitted,
James Vardell, M.D., President

Board Members:

James C. Vardell, Jr., M.D., President
Waitus O. Tanner, M.D., Secretary-Treasurer
Edward C. Mattison, M.D.
E. Craig Evans, M.D.
U. Hoyt Bodie, M.D.
Carter P. Maguire, M.D.

REPORT OF THE PRESIDENT OF THE STATE BOARD OF MEDICAL EXAMINERS

During the year, the South Carolina Board of Medical Examiners issued 460 permanent licenses to physicians as compared to 458 in 1983. Forty-one of the permanent licenses issued were by FLEX examination; and 419 were issued by endorsement of credentials from the National Board of other State Boards. Of the 460 permanent licenses issued, sixteen were issued to foreign medical graduates (seven by FLEX examination and nine by endorsement) as compared to a total of fifty permanent licenses issued to foreign medical graduates in 1983. Of the 460 permanent licenses, ten were issued to Doctors of Osteopathy. The FLEX examinations were administered by the Board in June and December. In June a total of fourteen applicants took the exam; ten passed and four failed. In December a total of eighteen took the exam; twelve passed with six failures.

In 1984 the Board promulgated a new Regulation (81-70) (Requirements for Limited Licenses of Interns, Residents, and Physicians). Limited Licenses are issued for medical training programs or limited practice approved by the Board and are for one fiscal year period or a part thereof. Limited Licenses were issued to 206 United States

graduates in 1984 and sixty-three Limited Licenses were issued to foreign medical graduates. In 1984 a total of ninety-four physicians were certified to other states, with a total of 101 certified to other states during 1983. Seven physician assistants were certified by the Board.

The Board of Medical Examiners also promulgated new regulations for Requirements for the Written Examination (FLEX) (81-80) and Requirements for License by Endorsement (81-90). These new regulations raised the Board's FLEX requirements from 70 percent per day on the examination to 75 percent per day with an overall average of 75 percent or better as well as require a new applicant who has been licensed in another state for more than ten years to either pass the National Board; pass the FLEX with this Board's current requirements and pay the FLEX fee; or if the applicant has a FLEX weighted average of 75 percent but does not meet daily FLEX requirements, applicant's certification by an American Specialty Board may be considered in lieu of satisfying daily FLEX requirements of the Board. These are only a few of the new criteria established by these new regulations which were sub-

mitted to the Legislature and approved during 1984 and are printed in the 1985 Directory published by the Board.

Regulation (81-81) (Oral and/or Written Examinations for Graduates of Medical Schools Located outside the United States or Canada) is another new regulation promulgated and approved during 1984. This regulation allows the Board to require satisfactory completion of an oral and/or written examination in addition to the ECFMG, FLEX and/or National Board Examinations of all applicants for licensure graduating from medical schools located outside the United States or Canada. Such an examination allows the Board to further ensure that the applicant is familiar with United States medical practices, procedures and policies.

Twelve Final Orders were issued by the Board during 1984; one Revocation; two Indefinite Suspensions; six Suspensions for a Specific Period of Time; one Public Reprimand; and two Private Reprimands. Four physicians voluntarily surrendered their licenses as a result of Board Investigations and one Order for Violation of Probation was issued.

Fifty-three complaints were filed with the Board during 1984. Each was investigated and either dismissed due to lack of evidence, followed through with a full investigation and a Final Order issued, or is currently under investigation or in litigation.

The Medical Directory of Physicians Licensed by South Carolina is printed each year. In the 1984-1985 Directory there are 4,487 physicians

listed in-state and 1,050 listed out-of-state.

The State Board of Medical Examiners held their four regular Board Meetings in 1984. Members of the Board also attended and/or participated in various committee meetings, group meetings, seminars, studies, as well as public hearings. Board members routinely attended and participated in state and national conventions and meetings, including the Federation of State Medical Board's Meeting in San Antonio, Texas.

The terms of Board members Dr. Spencer C. Disher, Jr., of Orangeburg, Member-At-Large; and Dr. William S. Houck, Jr., of Florence, Sixth Congressional District; expired in 1984. Both were reappointed. Dr. Anna Johnson of Summerville, Osteopathic Member; resigned (for health reasons) from the Board during 1984 and the Governor appointed Dr. Edward Antosek of Clover to fill this vacancy.

The terms of six members of the Medical Disciplinary Commission expired during 1984. Four of these were renominated and appointed: Dr. G. Alden Sweatman, Jr., of the Second District from Columbia; Dr. George W. Smith of the Third District from Easley; Dr. James C. Holler, Jr., of the Fifth District from Rock Hill and Dr. Julian P. Price of the Sixth District from Florence. Two new members were nominated and appointed: Dr. W. McGill Woodward of the First District from Charleston and Dr. Roy J. Ellison, Jr., of the Fourth District from Greenville.

Respectfully submitted,
J. Ernest Lathem, M.D., President

RESOLUTIONS

SUBMITTED BY: *Sumter-Clarendon Medical Society*

SUBJECT: **DUMPING OF TOXIC
WASTE IN SOUTH
CAROLINA**

WHEREAS, We the members of Sumter-Clarendon Medical Society feel that our foremost obligation is to protect the health and well-being of the citizens of this area;

WHEREAS, We feel that the hazardous waste landfill operated by G.S.X. (previously S.C.A.), currently doing business in Sumter County, poses a serious potential danger to the health and well-being of our citizens and all of South Carolina;

WHEREAS, In the past such landfills similarly situated and managed have been plagued with unforeseen leaks and hazards;

WHEREAS, The currently situated landfill overlies the vital aquifer which supplies water to an extensive population;

WHEREAS, The situated landfill lies immediately adjacent to one of South Carolina's most vital wildlife and recreational resources, the Santee-Cooper Lake system;

WHEREAS, The landfill itself and transport of these noxious and hazardous materials poses a serious potential threat to our entire state and region;

WHEREAS, We feel that DHEC has not provided the necessary examination, or re-examination for licensure, or public forum;

RESOLVED, That we are opposed to the dumping of toxic waste from other states into the state of South Carolina, and in particular we are opposed to the further operation of a toxic waste dump at Pinewood, South Carolina.

SUBMITTED BY: *Columbia Medical Society*

SUBJECT: **SEXUAL ABUSE OF S. C.
CHILDREN**

WHEREAS, Physicians are already required by South Carolina Statute to report suspicion of child sexual misuse to their local county Department of Social Services; and

WHEREAS, Child sexual misuse is a major problem presently recognized by the Second District; and

WHEREAS, Child sexual misuse should also be a recognized problem in all counties of South Carolina;

BE IT RESOLVED, That the Second District urges the South Carolina Medical Association to adopt a policy encouraging physicians to better recognize cases of sexual abuse that are presently under reported in most counties of South Carolina.

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Woodland Hills, California 91364

RESOLUTIONS

SUBMITTED BY: *Columbia Medical Society*
SUBJECT: **HEAD GEAR
REQUIREMENT FOR
HORSE SPORTS**

WHEREAS, Horse related activities play a major role in the recreational and economic lives of the people of the State of South Carolina; and

WHEREAS, Injuries related to such horse related activities are a major source of disability, and protective head gear has been shown to decrease the incidents and severity of head injuries;

BE IT RESOLVED, That delegates of the Second District go on record as urging all riders to wear proper protective head gear when engaging in horse sports, and that copies of this resolution be forwarded to the South Carolina Medical Association with a request for similar action, and to local newspapers.

SUBMITTED BY: *Columbia Medical Society*
SUBJECT: **UNNECESSARY
DIAGNOSTIC STUDIES
AND/OR TREATMENT**

WHEREAS, The costs of health care are recognized as a problem throughout this country; and

WHEREAS, Any unnecessarily extensive evaluation workups and treatments contribute to these costs; and

WHEREAS, Some physicians in this state have gained a reputation of being liberal with, if not exaggerating their estimates of impairment using some of these diagnostic studies and treatment modes; and

WHEREAS, If done knowingly this is certainly unethical practice.

BE IT RESOLVED, That the South Carolina Medical Association condemns such practice of increasing impairment ratings based on unnecessary diagnostic studies and/or treatments to build a practice or for any other monetary gain; and

BE IT ALSO RESOLVED, That anyone suspected of such practice be reported to the State Board of Medical Examiners for further investigation.

SUBMITTED BY: *S. C. Chapter American
Academy of Family
Physicians*

SUBJECT: **RESTRUCTURING THE
MEDICARE LAW**

WHEREAS, The Government is in deficit spending, and

WHEREAS, The Medicare System is in financial trouble and contributing to the deficit spending, and

WHEREAS, With advances in medicine the average lifespan is increasing, and

WHEREAS, Many patients over sixty-five require numerous hospitalizations, and

WHEREAS, Many Medicare patients have multiple medical problems and require much more time per office visit than the under sixty-five population, and

WHEREAS, Medicare reimbursements for office visits do not cover most physician's office overhead, and

WHEREAS, Many citizens at age sixty-five are financially secure with good hospital insurance and do not need Medicare, and

WHEREAS, Congress seems determined to make Medicare and assignments mandatory which would shift the cost of medical care from over sixty-five patients that are capable of paying their own bills to the under sixty-five patients, and

WHEREAS, The companies that are paying supplements to Medicare are only paying up to the allowed charges of Medicare which is approximately fifty percent of the medical bill leaving the over sixty-five year old patients with the responsibility of paying for fifty percent of their hospital expenses, now;

THEREFORE BE IT RESOLVED, That the South Carolina Medical Association urge Congress to (1) Restructure the Medicare law to include only patients that actually need Medicare, (2) To insure every patient over sixty-five the ability to continue their hospital insurance at a reasonable rate when they retire, (3) To guarantee catastrophic coverage regardless of income, and (4) To use the money saved to increase Medicare reimbursement to cover the physician's office overhead and prevent cost shifting to younger patients.

OLD BUSINESS

TABLED SCMA CONSTITUTION FROM THE 1984 HOUSE OF DELEGATES

The following proposed SCMA Constitution was presented at the 1984 Session of the House of Delegates and has thereby been tabled for the required eleven (11) months prior to final action by the House of Delegates. This is presented for final approval at the 1985 Session as follows:

SCMA CONSTITUTION

- 1.00 ORGANIZATION
 - 1.10 NAME OF THE ORGANIZATION. The name and title of this organization shall be the South Carolina Medical Association, Inc.
 - 1.20 PURPOSES. The purpose of this Association shall be:
 - 1) to serve the interest of South Carolina physicians and support their efforts to provide high quality medical care and promote good health for all citizens of the State.
 - 2) to serve as the voice of the medical profession of the State.
 - 1.30 COMPOSITION. SCMA, Inc., is a federation of component medical societies which shall be chartered by the House of Delegates upon the recommendation of the Board of Trustees.
 - 1.31 SUBSIDIARIES. Certain subsidiary organizations may be required to conduct the business of the South Carolina Medical Association, Incorporated. These will exist as separate legal entities structured and directed by SCMA, Inc. These organizations and their roles shall be addressed in the Bylaws.
- 2.00 HOUSE OF DELEGATES. The House of Delegates shall be the legislative and policy making body of the Association and shall be composed of elected representatives from component medical societies and others as provided in the Bylaws.
- 3.00 BOARD OF TRUSTEES. The Board of Trustees shall be elected by the House of Delegates at Annual Session as provided for in the Bylaws and will carry out the policies of the House between meetings of the House, and shall have authority over all of the subsidiary organizations, as well as other duties outlined in the Bylaws.
- 4.00 OFFICERS. The Officers of the Association shall be the President, President-Elect, the Past President, the Secretary, the Treasurer (if a member of the Association), the Speaker of the House of Delegates, Vice Speaker of the House of Delegates, and elected Board Members. Their qualifications and terms of office shall be as provided in the Bylaws.
- 5.00 SESSIONS AND MEETING. The Association shall hold an annual session, during which time there shall be a meeting of the House of Delegates and a general meeting, which shall be open to all members and guests. The time and place for holding such annual session shall be determined by the Board of Trustees. Special sessions may be held as provided in the Bylaws.
- 6.00 FUNDS. Funds shall be raised by the payment of annual dues by each member of the Association. The amount of annual dues shall be determined by the House of Delegates. A change in the amount of annual dues or any assessments shall not be made except by a two-thirds ($\frac{2}{3}$) vote of the Delegates present. Funds may also be raised by voluntary contributions, from the Association's publications, and in any other manner approved by the Board of Trustees.
- 7.00 THE SEAL. The Association shall have a common seal, with power to break, change or renew the same at the pleasure of the House of Delegates.
- 8.00 REFERENDUM. The House of Delegates may, by a two-thirds ($\frac{2}{3}$) vote of registered members, order a general Referendum upon any questions pending before the House of Delegates.
- 9.00 AMENDMENTS. The House of Delegates may amend any portion of this Constitu-

tion by a two-thirds ($\frac{2}{3}$) vote of the Delegates present at any regular session, provided that such amendment shall have been presented at least eleven (11) months prior in any regular session of the House of Delegates, and it shall have been sent to

each component medical society at least two (2) months before the session at which final action is to be taken.

Respectfully submitted,
Walter J. Roberts, Jr., M.D.
Speaker of the House of Delegates

SPECIAL GUEST: AMERICAN MEDICAL ASSOCIATION JOHN J. COURY, JR., M.D., CHAIRMAN, BOARD OF TRUSTEES

John J. Coury, Jr., M.D., Chairman of the AMA Board of Trustees, will address the SCMA House of Delegates on Thursday, April 25, 1985.

John J. Coury, Jr., M.D., a general and pediatric surgeon from Port Huron, Michigan, was re-elected Chairman of the AMA Board of Trustees in June, 1984. He was first chosen as Chairman in June, 1983, after having served as Vice Chairman of the Board since 1981.

Elected to the AMA's Board in 1976, Doctor Coury is a Past President of the Michigan State Medical Society. He has served as a Delegate to the AMA House of Delegates and as a member of the AMA Councils on Legislation and Long Range Planning and Development.

Born in Wheeling, West Virginia, on October 22, 1921, Doctor Coury graduated from Washington-Jefferson College in Washington, Pennsylvania, and earned his M.D. degree at Case Western University School of Medicine. His internship and residency training were received at Harper Hospital and Children's Hospital in Detroit. Doctor Coury is a Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons and the Detroit Academy of Surgery.

Doctor Coury is a member of the Mercy and Port Huron Hospitals' surgical staffs.

His community activities include membership in the Port Huron Chamber of Commerce and Trustee, Post Huron District Foundation. He is



also a member of the Port Huron Industrial Development Commission, and a former director of the United Way and the Catholic Social Services of St. Clair County.

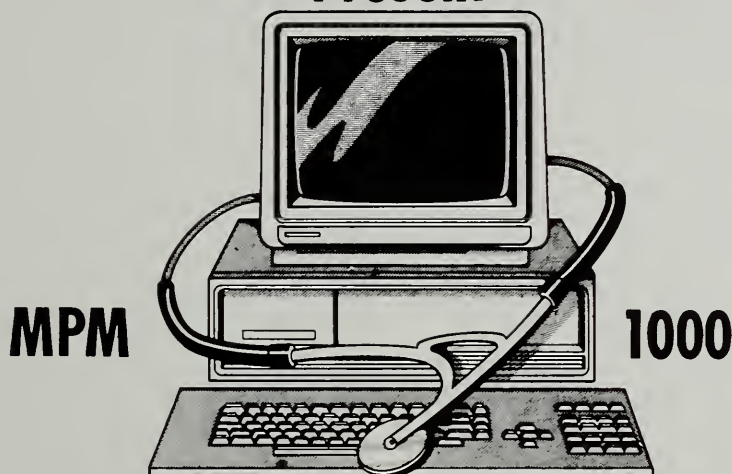
Doctor Coury is a member of the Lambda Chi and Alpha Kappa Kappa Fraternities. He and his wife, Doris, have three children.



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Editorial

SCREENING FOR HTLV-III ANTIBODIES — A GOVERNMENT BLUNDER?

Your cousin Nell goes down to the local Red Cross to donate a unit of blood. She is informed that her blood will be tested for antibodies to HTLV-III, the likely cause of AIDS, but this does not concern her for she has no reason to think that her test might be positive. However, one week later she is informed that her test was indeed positive and that the implications include the following: (1) her prognosis is uncertain, but she may eventually develop AIDS; (2) she must refrain from donating blood; (3) she is at risk of transmitting the infection to others by sexual intercourse, kissing, and other close contact; and (4) her toothbrushes, razors, and other objects should be regarded as contaminated. Nell's test result is indeed a false-positive, but no amount of reassurance or further testing can erase this stigma from her mind. She becomes a pariah, unable even to share intimacy with her husband. Her life is, in fact, ruined.

For some Americans, this scenario was made virtually inevitable by recommendations published in the January 11, 1985 issue of *Morbidity and Mortality Weekly Report*. The recommendations were formulated by five government agencies: the Centers for Disease Control; the Food and Drug Administration; the Alcohol, Drug Abuse, and Mental Health Administration; the National Institutes of Health; and the Health Resources and Services Administration. The manner in which the report was generated may even transcend its far-reaching implications. For the first time, a public health recommendation carrying implications for all Americans was formulated with no input or advice from the private sector.

The purpose of this editorial is to dispute the wisdom of the recommendation that "donors should be told that they will be notified if their test is positive." Let us first, however, review some of the basic premises:

(1) The designation "HTLV-III" applies to the third member of a recently-discovered family of human T-cell leukemia viruses. HTLV-III has a special tropism for helper (OKT4) lymphocytes.

(2) Mounting evidence indicates that HTLV-III is in fact the cause of AIDS. This evidence

includes the demonstration of antibodies to HTLV-III in up to 95 percent of AIDS patients and the isolation of the virus itself from over 90 percent of patients with early stage AIDS.

(3) The incidence of AIDS continues to rise dramatically in our population. Official tabulations in the United States indicated ten new cases during 1979, 46 during 1980, 252 during 1981, 980 during 1982, 2,643 during 1983, and 4,293 during 1984. Already, the case-fatality rate has been 48 percent, and most observers consider the process to be uniformly fatal. These considerations make AIDS the most challenging epidemic of our time. Legionnaire's disease and the toxic-shock syndrome pale by comparison.

(4) AIDS continues to be a clinical diagnosis. Basically, it is defined by the occurrence of a disease that is strongly suggestive of a defect in cellular immune function in a patient without other cause of impaired T-lymphocyte function. Recently, however, an enzyme-linked immunosorbent assay (ELISA) has been developed for screening for antibodies directed against HTLV-III. FDA approval of this test for wide application appears, at the time of this writing, to be imminent. The HTLV-III antibody test obviously offers the potential to identify whether a person has been previously infected with the virus now widely assumed to be the cause of AIDS.

(5) HTLV-III infection resulting in AIDS can occur from blood transfusions or administration of blood-derived products. The number of cases of AIDS occurring in hemophiliacs or occurring as a result of blood transfusions in the United States was 16 during 1982, 46 during 1983, and 102 during 1984. This risk was recently dramatized by the death of a San Francisco nun from transfusion-associated AIDS. Although only one percent of AIDS cases in the United States have been transfusion-related, the potential exists for a wider problem; fully 34 percent of AIDS victims in Australia have acquired the disease by this route.

(6) Close investigation of blood donors in a series of transfusion-related cases of AIDS led to the identification of high-risk donors (e.g., homosexuals or IV drug abusers) in 39 of 40 cases.

Already, blood banks routinely request that persons belonging to high-risk groups should refrain from donating blood.

(7) Availability of the HTLV-III antibody test offers an obvious method for "cleaning up the blood supply" and thus minimizing the risk of transfusion-associated AIDS, much in the same way that the test for the hepatitis B surface antigen dramatically reduced the risk of transfusion-associated hepatitis B. However, application of the antibody test to blood donors would result in knowledge about the HTLV-III antibody status of large numbers of persons.

(8) Various serologic surveys have indicated the presence of HTLV-III antibodies in 22 to 65 percent of homosexual men, 87 percent of IV drug abusers in New York City, 56 to 72 percent of patients with hemophilia A, and 35 percent of women with sexual exposure to AIDS patients, and fewer than one percent of persons with no known risk for AIDS. The long-term implications of HTLV-III seropositivity in asymptomatic persons is, however, unknown. Follow-up studies of HTLV-III seropositive homosexual men for two to five years has suggested that up to 19 percent may develop AIDS and that an additional 25 percent may develop the syndrome of generalized lymphadenopathy or other conditions associated with AIDS or "pre-AIDS."

(9) As with any other test, the ELISA assay for HTLV-III antibodies can have both false-positive and false-negative results. A major study indicated the test to be 98.6 percent specific (implying that the test would be false-positive in 1.4 percent of instances) and 97.3 percent sensitive (implying that the test would be false-negative in 2.7 percent of instances). While other tests (such as Western blot analysis and viral cultures) might help reduce the problem of false-positive results, it is still apparent that false-positive tests could occur.

(10) The finding of antibodies to HTLV-III suggests the risk of transmission of the AIDS virus. Unlike the situation with the hepatitis B virus, in which most patients with antibodies to the hepatitis surface antibody will lack circulating virus (antigen) in their blood, the HTLV-III virus appears to co-circulate with antibody in the majority of instances. Thus, the delicate issue arises: what to do about asymptomatic persons who are found to have HTLV-III antibodies? In contrast to other conditions of public health consequence for which serodiagnosis is available (syphilis is the best example), AIDS presently carries a dual terror: uniform fatality without treatment, and lack of an

effective treatment!

Armed with these considerations, the five government agencies listed above formulated their "inter-agency recommendations for screening donated blood and plasma for antibody to the virus causing acquired immunodeficiency syndrome." As one would expect from such an august body of well-informed persons, the recommendations seem, in general, to be well-founded. However many persons, including the present writer, take great exception to a single sentence: "Donors should be told that they will be notified if their test is positive. . .".

The problem of informing donors is twofold. On the one hand, innocent persons such as cousin Nell — coming to the blood bank for entirely altruistic reasons — will be informed of false-positive results, thus having their lives shattered. On the other hand, persons in high-risk groups — coming to the blood bank primarily to learn of their HTLV-III antibody status — will inevitable have false-negative results. Their blood, containing the virus, would then actually contaminate the blood supply and increase the risk of transfusion-related AIDS.

The solution seems simple. Blood banks should continue to discourage donors belonging to high-risk groups, but test all donors for HTLV-III antibodies. Blood with a positive test would simply be discarded. The donors would not be informed. Innocent persons would not be victimized, and persons belonging to high-risk groups would not flock to the blood banks to learn of their antibody status. Unfortunately, the legal opinion given to the blood banks thus far seems to be that they will have the duty to inform donors — again because of the inter-agency recommendations.

In my opinion, this avoidable and unnecessary quandary arose because of the government agencies' failure to distinguish between epidemiologic concerns and clinical concerns. The skilled epidemiologist takes a broad view of his terrain in order to solve problems pertaining to the population. The skilled clinician takes a narrow view of human concerns in order to promote the well-being of the one patient before him or her. Seeking to reduce the risk of AIDS to others, the epidemiologist accepts the inevitability that an occasional cousin Nell will suffer from the recommendations. Seeking to protect cousin Nell, her physician has every reason to view such a policy as reckless. Our creed is not "first, prevent illness in others"; it is "first, do no harm."

Our government agencies — notably the Cen-

ters for Disease Control and the National Institutes of Health — deserve a great deal of credit for efforts to understand and control AIDS. This epidemic is without precedent. However, the decision of these agencies to formulate far-reaching guidelines with no private sector input is also without precedent, and the results could be extremely dangerous and divisive. In South Carolina, we are extremely fortunate to have professionals such as Dr. Robert Jackson and his able staff at DHEC who are working actively with blood banks and other persons to interpret these recommendations for the best interests of our citizens. At the same time, we must sympathize with the sentiments of at least one newspaper commentator: "When we begged the government to stop this epidemic, we never dreamed the price would be to stop our struggle to share basic human dignity."

This episode should serve as a lesson that in

health matters, government must consult the private sector before making far-reaching recommendations. No matter how complex, such issues require careful application of the Golden Rule. In applying the Golden Rule, it is quite possible that the collective wisdom of five government agencies may be no better — and perhaps worse — than the thoughtful judgment of a single concerned country doctor.

— CSB

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4. McFarlane R: Test is dangerous, should never be used. *USA Today*, February 6, 1985, p. 6A.

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LETTERS TO THE EDITOR

MEDICAL STUDENTS

To the Editor:

Kudos to Dr. Newberry! His editorial, "Medical Student, Medical Student: Where Art Thou?" (January issue), was right on the money. Reading between the lines of this discerning treatise, I surmise the following: (1) we reward our faculty financially based on generated service income; (2) we reward them academically based on research grants secured and manuscripts published; (3) we expect them to teach, but offer no tangible rewards for this endeavor; and (4) we need to make some changes!

C. Warren Derrick, Jr., M.D.

Professor and Chairman
Department of Pediatrics
University of South Carolina School of Medicine
Columbia, S. C.

THE DEATH PENALTY

To The Editor:

I read Dr. Hunter's article about the death penalty in the January issue of *The Journal*, and I agree with his ideas. I think that oblivion is an appropriate punishment for those violent criminals who commit particularly heinous crimes. I also agree that we should allow these persons to take their own lives if they decide to do so, after some length of time. We could argue about details, but I won't waste time with that now.

I hope that Dr. Hunter's idea catches on. I am not optimistic, for I don't believe that the courts would allow it. It would be considered cruel and unusual punishment, and many lawsuits would result. Of course, this should not deter enlightened discussion that, hopefully, has been started.

David C. Morris, M.D.
West Columbia, S. C.

To the Editor:

One vote for Dr. Hunter's idea! I suggest that the cup should be offered — or made available — all of the time.

William S. Lyles, M.D.
Winnsboro, S. C.

To the Editor:

My name is Trey Gowdy and I'm a junior at Baylor University in Waco, Tx. My father, Hal Gowdy, is a pediatrician in Spartanburg, S. C. I'm a history major so your article on capital punishment interests me more from a legal standpoint than a medical one.

I agree with your stance on capital punishment. Your "alternative" was creative and controversial. I trust that you realize the suggestion you made cannot be regarded as a Christian alternative. Suicide, of course, is not a proper way of ending life from a Christian perspective. I believe sincerely that Christ's response would be, to criminals, "go and sin no more." We are not Christ, nor is our government an example of Christianity. We must punish offenders of heinous crimes. I agree in practice with your theory if not in theory.

I offer my assistance in any way possible. I applaud your article, stand and alternative.

Trey Gowdy
Waco, Texas

ON THE COVER

SOUTH CAROLINA MEDICINE AND THE SEA

In 1666, the first physician landed in South Carolina. Described by Effie Leland Wilder as the “forgotten man in American history,” Henry Woodward (pictured below), ship surgeon, came ashore to participate in the assessment of Carolina for the Lords Proprietors and King Charles II. When his ship left, Woodward remained, becoming not only South Carolina’s first physician, but our original English settler.

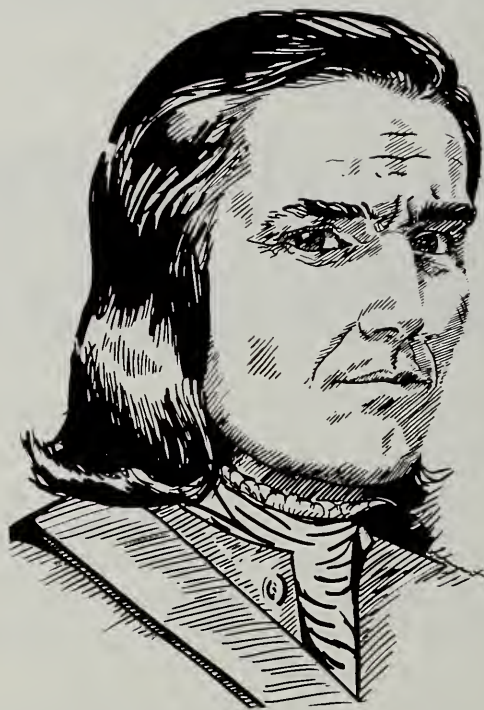
April, 1985, witnesses the return of a greater number of physicians to Charleston as the SCMA holds its 137th annual convention in that city. Just across the Ashley River from the convention location is Charlestowne Landing, the original settlement site and home of *The Adventurer* (pictured on the cover), a replica of a 17th century coastal trading ketch. The marvelous cover photo taken by *News and Courier* photographer, Bill Murton, captures two worlds as *The Adventure* yields to a ballistic nuclear submarine with Charleston’s church steeples in the background.

The importance of marine traffic in South Carolina’s early development is well known, but not so obvious as the role the sea played in the early history of medicine in South Carolina. With its bounty, the sea also brought unwelcomed guests. Disease brought in by infected sailors was an extremely serious problem; thousands upon thousands died. The attempts to control infectious epidemics resulted in a major expenditure of manpower and money by the struggling young colony.

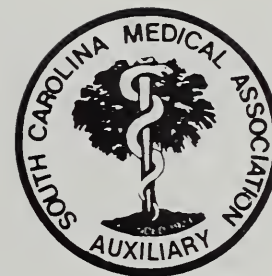
The first quarantine (or “pest house”) was built on Sullivan’s Island in 1707. It remained in use until swept away by the great storm of 1752. A few of the major epidemics introduced by the sea (and by her human cargo who frequently broke quarantine regulations) were the smallpox epidemic of 1738 brought in from New Guinea by slaves; the 1767 “fatal flux and fevers” brought in by the new Irish immigrants; the 1771 smallpox epidemic caused by West Indies slaves; the measles epidemic of 1782 imported from Philadelphia; and a cholera epidemic in 1832. The biggest killer of the time, yellow fever, made frequent appearances from 1699 on. It was rampant in the 1850’s and quarantine breaking ships from St. Thomas and Havana constantly reinfected the coastal states.

But if our first physician, Dr. Woodward, could return to Charleston with today’s physicians, he would find a city freed from the scourges of major epidemics. He would find magnolia and dogwood scenting the gentle sea breezes that welcome back South Carolina physicians to refresh their minds professionally, and he would hear the bells and the gulls and the oyster snaps at low tide. And he would be reminded of the myriad ways in which the rich heritage of medicine in South Carolina has been influenced by the sea.

— THOMAS M. LELAND, M.D., Ph.D.



SOUTH CAROLINA MEDICAL ASSOCIATION AUXILIARY



REPORT OF THE PRESIDENT OF THE SCMA AUXILIARY TO THE 1985 SCMA HOUSE OF DELEGATES

"Reach high — the finest things of life are on the topmost shelf. . . ." The 1984-85 Auxiliary year began with that challenge to South Carolina Auxilians. The year has ended with that challenge having been well met, and new and exciting avenues of service opened to us through the commitments of South Carolina Auxilians.

The Auxiliary quest to reach high began on May 9, 1984, during our Spring Workshop at Spring Valley Country Club in Columbia. Peggy G. Deane, R.N., Vice President of Anderson Memorial Hospital, was our keynote speaker. Her talk was directed toward the future trends of medical practice and its impact on physicians' spouses. For the second year, an exhibit area was added to workshop. Exhibits included Health Projects, Doctors Day, Child Protection, Membership, Legislation and the State Museum. Our roundtable discussion group format was very well received. Participants gleaned excellent information from Auxiliary leadership during these sessions. Plans have been made to expand the workshop to a full day for the 1985-86 meeting.

During the 61st Convention of the American Medical Association Auxiliary, Mrs. Wayne C. Brady (Billie) of Greenville was installed as President of the American Medical Association Auxiliary. The South Carolina Delegation (Association and Auxiliary) responded to this challenge with much energy and enthusiasm. We were very visible during the week wearing Billie's favorite peach and white colors along with banners depicting South Carolina's seashore treasures. On Wednesday, June 20, Dr. Kenneth Owens and Dr. Donald Kilgore presented Billie with telegrams from Senators and Congressmen along with flowers and gifts from the South Carolina Medical Association and the Greenville Medical Society. Billie received gifts from the Greenville Auxiliary, presented by Mrs. Charles Duncan and from the South Carolina Medical Auxiliary. On Wednesday afternoon, Dr. Ken Owens and I shared the privilege of greeting the hundreds of people attending a reception in Billie's honor immediately following her inauguration. The reception was planned and sponsored by the Auxiliary and the Association. Those attending received a small gold dipped sand dollar as a remembrance of a special and historic day for the SCMA and SCMA Auxiliary.

Through the cooperation of the Risk Management Committee, chaired by Dr. Euta Colvin and the Joint Underwriters Association, a brochure entitled *Understanding Malpractice Claims, A Guide for Physicians and Spouses* was mailed to every physician in South Carolina during the summer. A cover letter detailing the Risk Management program and Auxiliary support groups was enclosed.

Membership has been a priority for the Auxiliary this year. Under the direction of Dr. Susanne Black, SCMAA Membership Chairman, we have achieved our Fair Share goal of 80 new AMAA members as established by the national auxiliary. It is our anticipation that membership for 1985-86 will exceed previous years. Several projects have prompted this expectation. We challenged, for the first time, another state to see which state could receive the greatest increase in full dues paying members. Washington State accepted the challenge "from sea to shining sea" was on. When we win, our reward is to be a 20+ pound fresh northwest salmon. If we should lose, Washington will receive 10 pounds of South Carolina's finest

pecans. We do not, however, expect to carry pecans to Chicago in June. Susanne implemented a membership roundup during the first two weeks in February culminating on Valentine's Day, February 14. Her interest and encouragement has been shown in an excellent response to membership this year.

South Carolina Auxilians have been involved in the Legislative arena during 1984-85. In July we began Project MED VOTE. MED VOTE was the AMA's bipartisan program to identify unregistered members, their spouses and family members, register them to vote and encourage their active participation in the 1984 general election. The results of this project were both thrilling and frightening. In most of the smaller communities, we found that well over 85 percent of the medical families were registered. In our larger areas, registration swung from a low of 32 percent to a high of 56 percent. Various factors such as resident programs, military personnel and foreign born physicians contributed to the lower percentages. Mrs. William Meehan of Aiken chaired this project. Another legislative first is the sponsorship of a political seminar during the Annual Meeting in Charleston. Michael Dunn, a political consultant to AMPAC will be featured as the speaker. The two hour seminar will be on political "how-tos." The Auxiliary also heartily endorses and supports PAC activities. We encourage auxilians to become active members of SOCPAC and AMPAC and to proudly wear their 99+ pins.

As the Auxiliary entered our eleventh year of involvement in the area of Child Abuse and Neglect, we felt it was time to celebrate these years spent on behalf of children of South Carolina in a very positive way. Plans are currently being made to present for physicians and their spouses a seminar on Prevention of Child Abuse during the fall of 1985. These plans are being developed through the joint efforts of the SCMA, SCMA Auxiliary, the South Carolina Chapter of the American Pediatric Association and the South Carolina Academy of Family Physicians. The Auxiliary continues to be the catalyst for the South Carolina Child Protection Advisory Committee. This committee, formed in 1972, gives the agencies providing child protection services an opportunity to meet and work together. Two programs are sponsored each year by the Committee with one of the programs based on continuing education in the field of child protection.

For the second year, Madge Littlejohn has chaired our AMA-ERF Committee. Through various county projects, we have again surpassed our total as of this time last year. On February 21 our total giving was \$20,500. Tickets are being sold for an exquisite cross-stitched quilt done by auxiliary members and friends of auxiliary, and also for a gold bracelet with a value of \$250. Both items will be drawn for during the Convention and our coffer for AMA-ERF will increase. An apron with the pineapple logo, a new item this year, was developed and sold. The Oconee Auxiliary held a celebrity auction in memory of Dr. Hugh Wells and raised approximately \$1,000. The Anderson Auxiliary held a Holiday House during December and proceeds from a Christmas Boutique were designated for AMA-ERF. Other fund raising success stories have included a tasting party (Greenwood County raised its highest amount ever), a series of mini-courses with registration fees benefiting AMA-ERF, a game card party, and of course, our perennial favorite and best fund raiser, the Christmas Sharing Card. During Convention, Madge will present checks to the Deans of both the Medical University of South Carolina and the School of Medicine in Columbia.

The Fourth Annual School Nurses Workshop was held in Columbia in August. Each year, the quality of the workshop and the participation of the school nurses continues to grow. This is the fourth year that the Auxiliary has combined efforts with the Department of Education and DHEC to provide this workshop. We feel it is indeed a worthwhile endeavor for the Auxiliary.

The counties of Sumter, Dorchester, Greenville, Lexington, Charleston and Marion were represented during Leadership Confluence in Chicago, October 13-16. Auxiliary Presidents-Elect from these counties along with Mrs. Kenneth Smith and Mrs. Warren Y. Adkins attended seminars and workshops on enhancing our leadership skills and developing new membership and health projects. Mrs. Wayne C. Brady, AMAA President, and Mrs. S. Perry Davis, national Membership Committee member, were also in attendance.

Our scholarship recipients will be introduced in *SCAN* and the *SCMA Journal*. Again this year, we are awarding four scholarships of \$750 each. Two students from each medical school will be selected to receive these scholarships. Several county Auxiliaries continue to give scholarships in the medical and paramedical fields.

The Executive Board of the SCMA Auxiliary was honored to have as their keynote speaker in October, the President of the South Carolina Medical Association, Dr. Kenneth N. Owens. Dr. Owens attended our Board meeting that morning and shared with us some very valuable information during his presentation. Also joining us were Dr. Charles R. Duncan, Chairman of Council and Mr. William Mahon, Executive Vice President, SCMA.

During our Board meeting, Dr. George Grimball, Chairman of the SCMA Committee on Impaired Physicians, discussed impaired physicians and the role the physician's spouse plays in obtaining help for these persons. The Pickens Auxiliary presented a skit, "C. S. and Company," which deals with drug abuse and alcoholism for school age children. The skit was written by a Pickens Auxiliary member. Several other auxiliaries have begun to use this skit in their own communities.

The Greenwood Auxiliary continues its Chemical People project, a program to fight school age drug and alcohol abuse. Spartanburg is showing their drug education film, "Breaking Free," in area schools. They also co-sponsored a drug education conference for the public last November. The Colleton Auxiliary is presenting eight hour-long sessions to area fourth graders designed to enhance the students' self esteem, thus decreasing the likelihood of alcohol and drug abuse. A similar program is being done in Dorchester County. Several counties have been added to our list of counties involved in some way with Loaner Seat Programs. Involvement has ranged this year from purchasing seats and manning the loaner/rental/purchase program to giving an infant seat on Doctor's Day to the first baby born on March 30 in honor of area physicians, to a LOVE SEAT given to the first baby born on February 14. Auxiliaries are addressing the problem of teenage pregnancies and developing programs to educate pregnant teens on proper nutrition and good health habits.

The Auxiliary has had quite a few "firsts" for this year and one of the most important ones has been Donna Murphy. The talent and expertise she has applied to Auxiliary affairs has been of immense service to all Auxilians. Her professionalism, and most especially, her willingness to help has affected all those who have worked with Donna. We are most grateful to the South Carolina Medical Association for providing us with this "first."

The South Carolina Medical Association continues to provide us with guidance, support and assistance in the many endeavors we undertake to improve the quality of life for South Carolina. For that, we are most grateful.

Because of the concern and commitment of South Carolina physicians and their spouses, this year has been a year of unsurpassed highs. I thank you for the honor and privilege of viewing "life's topmost shelf" through Auxiliary this year.

A handwritten signature in cursive script that reads "Linda".

Linda K. Smith (Mrs. Kenneth W. Smith)
President, SCMA Auxiliary 1984-85

EXHIBITORS FOR SCMA 1985 ANNUAL MEETING

1. Fenwick Hall Hospital
2. Wallace Laboratories
3. U. S. Navy
4. Travenol Laboratories
5. International Medical Electronics, Ltd.
6. MEDFAX Corporation
7. U. S. Air Force Health Professions
8. Hoechst — Roussell Pharmaceuticals, Inc.
9. Roche Biomedical Laboratories
10. American Express Company
11. Miles Pharmaceuticals
12. G. Geisler Group
13. Bio — Dynamics
14. Charter Rivers
15. Parke-Davis
16. Bureau of Home Health Services — DHEC
17. Abbott Laboratories
18. The Charles Stedman Group
19. Bristol Laboratories
20. Bureau of Laboratories — DHEC
21. Winchester Surgical Supply Company
22. MI Professional Management
23. & 24. Southern Medical Association
25. Sandoz Pharmaceuticals
26. The Medical Protective Company
27. McNeil Pharmaceuticals
28. Ortho Pharmaceutical Corporaton
29. & 30. Blue Cross/Blue Shield of S. C. Computer Services Division
31. H. Jack Free Advisory Corporation
32. Lederle Pharmaceuticals
33. Merck Sharp & Dohme
34. U. S. Army Medical Department
35. S. C. Consortium of Community Teaching Hospitals
36. CIBA Pharmaceutical Company
37. Southern Pines Hospital
38. Mead Johnson Nutritional Division
39. Smith, Kline & French Laboratories
41. DuPont Pharmaceuticals
42. Wyeth Laboratories
43. McNeil Consumer Products Company
44. Pfizer Laboratories
45. MUSC Alumni Association
46. & 47. S. C. Department of Health & Environmental Control
48. S. C. Vocational Rehabilitation Department
49. AT & T Information Systems
50. William H. Rorer, Inc.
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President's Page



LOOKING AHEAD

I would like to take advantage of my first President's Page to express my sincere appreciation for the honor of serving as President of the South Carolina Medical Association. I will do my very best to merit your confidence.

My special thanks to Dr. Ken Owens for the very fine job he did in representing the SCMA during this past year.

I plan to be in close touch with you as members of the SCMA during the coming year. I want to hear from you by letter or by phone at SCMA Headquarters or at my office in Belton. Let me know what you as physicians in South Carolina want the SCMA to be doing; what issues and directions you want stressed. Let me hear from you.

Along this line, I will be sending a letter soon to solicit invitations to visit your county medical society meetings. It is my desire to visit *every* organized society at least once during my tenure as President, so please invite me. If you don't, I will ask again!

There are some specific things I plan to stress during my tenure as President. I would not want us to lose sight of the association's long range goals, as developed by the Planning Commission and approved last year by the House of Delegates. Specific goals which we will address include the following:

- Promote high professional standards and ethics in medical practice. Those of you who heard my inaugural address last month know that this is an area of particular interest to me — professionalism, ethics and community/social involvement from all physicians.
- Seek policies for quality, cost-effective and accessible medical care with fair payment for physician services.
- Seek to achieve public understanding, acceptance and support for the medical profession and the complexities of delivering quality medical care. In this area, we will make extensive use of our public relations consultants and SCMA staff — to tell our story, what medicine is doing and where we are today.
- Represent the interests of physicians and quality medical practice to all organizations and groups involved in health care.
- Maintain active participation in legislative and governmental matters which affect the medical profession. This is an activity which we intensified over the past year and which we will continue to expand as our tort reform legislation is introduced in the fall.
- Achieve membership growth and active membership participation in the affairs of the association. Membership is vital to our efforts in all the areas we plan to address.

We have come a long way this past year. We must keep up the momentum. We have an excellent SCMA staff that is eager to represent the physicians of South Carolina. Please call on them. You will find them to be extremely helpful.

And when you are asked to serve on an SCMA committee, please do so with enthusiasm. In appointing committees for this coming year, prior to the Annual Meeting, it was distressing to find that a good number of physicians we wanted to utilize had not paid their 1985 dues. SCMA policy is that only SCMA members in good standing may serve, so please pay your dues early!

Sincerely,

LEONARD W. DOUGLAS, M.D.
President



THE JOURNAL

OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

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NUMBER 5

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INFORMATION FOR AUTHORS

Authors should refer to the detailed instructions in the January issue. Manuscripts and other correspondence should be addressed: The Editor, JOURNAL OF THE SOUTH CAROLINA MEDICAL ASSOCIATION, Post Office Box 11188, Columbia, S. C. 29211.

All manuscripts should be accompanied by a transmittal letter with the following paragraph: "This original work has not been submitted or published elsewhere, in entirety or in part. I (we) hereby transfer, assign, or otherwise convey all copyright ownership to the South Carolina Medical Association in the event that this work is published by the SCMA."

We request that manuscripts be concise (no longer than 8 typewritten pages, double-spaced), with no more than ten references. These should be cited in the text in superscript, e.g., "Bottsford, et al.³", and should conform to the following style: "3. Bottsford JE, Bearden RC, Bottsford JG: A ten year community hospital experience with abdominal aorta aneurysms. *J S C Med Assoc* 79: 57-62, 1983." Ordinarily, publication of four small illustrations or tables or the equivalent will be paid for by *The Journal*. Manuscripts should be submitted in duplicate. Reprints will be made available by the publisher.



OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

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IMPROVED RESULTS IN RECTAL CARCINOMA WITH PRE-OPERATIVE RADIATION*

RICHARD D. MARKS, M.D.**

KEENE M. WALLACE, M.D.

TERENCE N. MOORE, M.D.

JOHN HAWK, M.D.

ALBERT KREUTNER, M.D.

Memorial Hospital and the Sloan Kettering Cancer Center reported an improved survival in the treatment of carcinoma of the rectum with pre-operative radiation therapy as early as forty years ago.^{12, 13} Orthovoltage x-rays were used to a modest dose of approximately 2000 rads and only patients thought to have advanced lesions were selected for treatment. In most cases an AP resection followed the pre-operative radiation treatment. Since this time there have been numerous reports describing retrospective studies but few randomized studies concerned with the various techniques of administering pre-operative irradiation therapy for carcinoma of the rectum.^{1, 5, 7} Most of these reports reveal that the radiation therapy offers a substantial and statistical survival advantage in patients with late stage disease over surgery alone regardless of the radiation therapy dose utilized. It is because of this fact that many surgeons prefer that their patients with low rectal carcinoma or extensive tumor receive pre-operative irradiation. This has been a preference of

some surgeons in the Charleston, South Carolina area and during the past ten years our records reveal 105 patients referred for pre-operative treatment for rectal carcinoma. The results of 71 of these patients followed from five to ten years will form the basis of this report.

MATERIALS AND METHODS

From January 1, 1973 to January 1, 1983, 105 patients received planned irradiation prior to the surgical procedure for adenocarcinoma of the rectum and distal colon. Seventy-one patients with a five year minimum follow-up will be discussed in this report. All patients had a pathological diagnosis of cancer. The average age was 64, 69 were caucasian and the sex ratio was equal. All patients were treated with a high energy linear accelerator at the Medical University of South Carolina Hospital or a 60 Cobalt teletherapy unit at Roper Hospital. No chemotherapy was used in conjunction with the radiation therapy. The dose range was from 2500 rads in two weeks to 4500 rads in five weeks at a rate of 180 to 200 rads per day. Over 50 percent of the patients received 4000 rads in four weeks or greater. See Figure I. Because the dose was limited in most patients, a simple whole pelvic anterior posterior field was used which covered the perineal region. Surgery was carried out or attempted in three to six weeks after completion of the radiation therapy.

* From the Departments of Radiology (Drs. Marks, Wallace, and Moore) and Pathology (Dr. Kreutner), Medical University of South Carolina, and the private practice of surgery (Dr. Hawk), Charleston, S. C.

** Address correspondence to Dr. Marks at the Division of Radiation Oncology, Medical University of South Carolina, 171 Ashley Avenue, Charleston, S. C. 29425.

RESULTS

Not all patients had a definitive surgical procedure and some had no further treatment after radiation therapy. The distribution and type of operative procedures are shown in Table I. Forty-eight percent of operable patients had an AP resection, 21 percent had an anterior resection, nine percent had a local excision and 22 percent had no surgery. Since the staging for rectal carcinoma is a surgical pathological one, only those patients having a definitive procedure could be staged. The Astler Collier Modification of the Duke Staging System was used for these patients.² The distribution of stages is shown in Table II. It can be seen that 46 percent of the patients had a C1 or C2 lesion even after pre-operative radiation therapy. When the group of patients with C lesions is added to those patients who were not resected it appears that 62 percent of our patients had advance local cancer.

The five to ten-year follow-up data are shown in Table III. There were no local recurrences in the 49 patients having a definitive surgical procedure. One patient is alive having received radiation therapy only and two patients remain NED after have a local resection. The absolute five year survival is 41 percent. There does not seem to be any correlation between the dose administered and the survival nor between the dose and percentage of local control. The five year survival for the patients with C lesions was 41 percent and for patients with B1 or B2 lesions is 55 percent. Figure II. The local control has been shown to be 100 percent.

FIGURE I

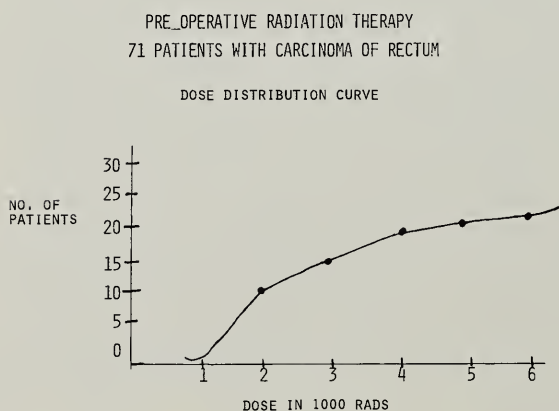


Table I
PRE-OPERATIVE RADIATION THERAPY
71 PATIENTS WITH CARCINOMA OF RECTUM

Type of Surgical Procedure and Distribution	Number	Percentage
NO FURTHER TREATMENT	13	22%
COLOSTOMY ONLY	1	1%
LOCAL EXCISION	6	9%
ANTERIOR RESECTION	15	21%
AP RESECTION	34	48%
LOST TO FOLLOW-UP	2	3%

Table II
PRE-OPERATIVE RADIATION THERAPY
71 PATIENTS WITH CARCINOMA OF RECTUM

Pathological Findings in 49 Surgical Patients

Type of Surgery	A	Pathologic Stage				Met. Disease	No Residual Cancer
		B		C			
		B1	B2	C1	C2		
AP-Resection Anterior	3	9	6	3	9	2	2
Resection	0	1	3	2	7	1	0
Total	3	10	9	5°	16°	3	2+

* 21 Positive Nodes = 46%

+ 5% Sterilization of Cancer

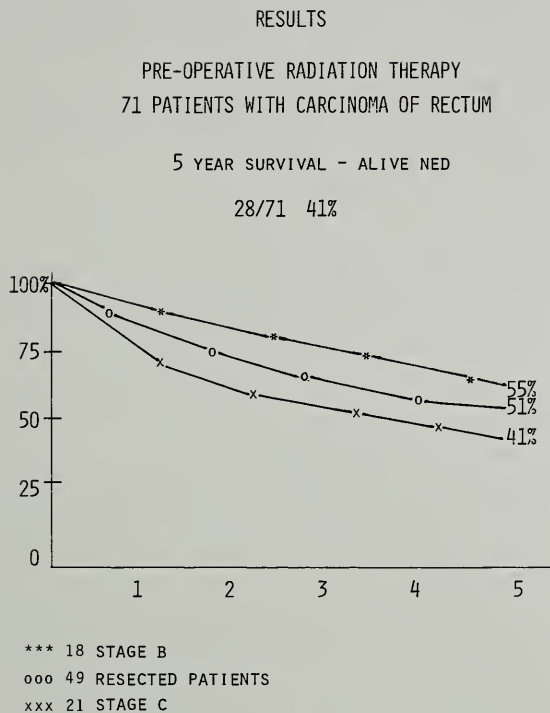
Table III
PRE-OPERATIVE RADIATION THERAPY
71 PATIENTS WITH CARCINOMA OF RECTUM

Results of Treatment — Follow-up 5 to 10 Years

Groups	Results				
	No	NED	Loc Rec	Met	Dead from Intercurrent Disease
RT & Definitive Surgery	49	29	0	17	8
RT & Local Excision	6	2	1	3	0
RT & No Surgery or Colostomy	14	1	13	1	0
Lost to Follow-up	2	0	0	0	0
Total	71	28	14	21	8

RECTAL CARCINOMA

FIGURE II



DISCUSSION

To the radiation oncologist these results are not surprising. Two factors are surprising, however. First, since carcinoma of the rectum is such a common disease and the results with advanced patients are poor, it is surprising that more patients were not referred for adjuvant pre-operative radiation therapy. Second, it is difficult to explain the improved results in virtually all patients, even with the lower dose of pre-operative radiation treatment.

Historically the Roswit Higgins long term VA study and the earlier Memorial data, both showed some improvement with a lower dose of pre-operative radiation.⁵ Historically the Allen study from Oregon and the results by Kligerman from Yale, both indicated a very substantial improvement with a higher preoperative dose regimen, i.e. 5000 rads and 4500 rads respectively.¹⁻⁹ An attempt in 1974 by a RTOG randomized study to answer this dose question and to compare 2500

rads to 4500 rads, failed. It failed because many surgeons were convinced that pre-operative irradiation was of benefit thus they avoided the study or they preferred only a low dose of radiation therapy.¹ The study was not completed due to lack of patient accession.

Although there was unanimous agreement among the four radiation oncologists in our department that 4500 rads was the pre-operative dose of choice, the eight referring surgeons accepted a pre-operative dose that ranged from 2500 to 4500 rads. There are many advantages of pre-operative irradiation, especially in patients who have stage C1 or C2 carcinoma. They are: (1) large, bulky invasive tumors may be made resectable after pre-operative irradiation, (2) small lymph nodes not removed or appreciated at the time of surgery may be sterilized, (3) cancer cells spilled or left at surgery or appear as a multifocal lesion may be irradiated with treatment, (4) cancer cells that are manipulated at the time of surgery may be made sterile prior to their dissemination.

Three of these theoretical advantages were apparent in this group of patients. Local control was excellent, survival acceptable, and resectability improved. Although a substantial percentage of patients developed metastatic disease, this is probably due to the advanced nature of the disease.

The possibility that post-operative irradiation may have advantages over pre-operative irradiation has been postulated by Gunderson and others.⁴ We do not argue with this fact and can simply state that if patients need adjuvant radiation, they can probably be equally benefited by either radiation therapy before or after surgery, provided it is adequate in terms of dose and coverage. One has to be flexible concerning this point, and in fact at our institution, we have adopted the following policy. Those patients with fixed low rectal tumors or borderline operable lesions receive high dose preoperative irradiation therapy, i.e., approximately 4500-5000 rads in five weeks. All other patients receive 800 rads in two fractions immediately prior to surgery and if indeed they have B2 or C lesions, 4500 rads are administered post-operatively. It is premature to determine the benefit from this regimen, although the preliminary results from a similar approach at Jefferson University in Philadelphia are very encouraging.¹¹ A recent GI Tumor Study Group involving patients with B2, C1, and C2

lesions indicated a significant improvement in local control with the addition of post operative irradiation therapy, but no significant difference in overall survival.

In conclusion, from the results of this study and from historical experience, we can say that patients with the large low lying rectal carcinoma may have a greater than 50 percent chance of recurring and a 25 percent chance of living five years. These patients can have their prognosis substantially improved by the addition of pre-operative radiation therapy. It appears from the literature that results may be better with the higher dose, in the range of 4500 rads in five weeks; however, this report would indicate that any course of adequate irradiation therapy improves the overall results. No significant life threatening or long term complications were detected in the follow-up evaluation of these patients. It is also interesting to note that these results were accomplished without the concomitant or adjuvant use of chemotherapy.

SUMMARY

During a 10-year period from January 1, 1973 to January 1, 1983, 105 patients with adenocarcinoma of the rectum were treated with pre-operative radiation therapy. Seventy-one of these patients with a minimum of five years follow-up form the basis for this report. The majority of these patients were referred because of borderline operability. Sixty percent of the patients received a dose of 4000 rads or more. A 95 percent complete follow-up is available and 49 patients had a definitive surgical resection. Of the 49 patients having a definitive resection, no patients have developed a local recurrence. Twenty-five or 51 percent of the 49 patients resected are alive NED and the five-year survival for this group was 66 percent. Twenty-eight percent of the 49 resected

patients who failed died from metastatic disease. The majority of the patients who failed died from metastatic disease. Twenty-eight of the 49 resected patients were stage C disease. A five-year absolute survival figure for the 71 patients, which includes those non-resected patients and patients dying of intercurrent disease, was 41 percent. □

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CHLAMYDIA TRACHOMATIS IN A HIGH RISK PREGNANT POPULATION*

HAROLD D. GABEL, M.D., M.P.H.**

JANICE BACON, M.D.

HAROLD DOWDA, Ph.D.

EDWIN E. SHEARIN

MICHAEL ARVELO

According to the Centers for Disease Control, *Chlamydia trachomatis* is currently the most prevalent sexually transmitted disease producing organism in the United States. It has been estimated that there are three million cases of chlamydial infection annually in the United States. This is compared to an estimated two million of gonorrhea.¹ Infections caused by serotypes D, E, F, G, H, I, J, K of this unusual obligate intracellular bacterium are of particular interest as both the ocular and urogenital systems of both males and females may be affected. In fact, *C. trachomatis* is alleged to cause between 30 to 50 percent of urethritis, 50 percent of epididymitis, and 20 to 30 percent of proctitis in men.² In women, it is responsible for between 40 to 60 percent of mucopurulent cervicitis, 10 to 20 percent of salpingitis, and has also been implicated as a factor in infertility, prematurity, low birth weight, and neonatal mortality.²

In reported studies, *C. trachomatis* has been isolated from the cervix in seven to 20 percent of pregnant women.¹ This can result in post partum complications such as fever and endometritis, but of equal or greater concern is that 20 to 50 percent of the infants born to infected mothers will develop conjunctivitis and between three to 20 percent will develop pneumonia.³

To determine the prevalence of this organism in our patient population, a sample of 369 consecutive pregnant women at various stages of ges-

tation were cultured for *C. trachomatis* between July 16, 1984, and August 10, 1984. These women attended the Richland Memorial Hospital prenatal clinics. Richland Memorial Hospital is the county hospital for Richland County, which includes Columbia, S. C., and is a regional center for a seventeen county referral area. The hospital serves a population of mostly medically indigent patients.

Cultures of the endocervical canal were obtained using a cotton-tip applicator and were packed in dry ice and transported in 2 SP medium to be grown on McCoy cell cultures. Of the 369 cultures that were obtained, 34 cultures were unsatisfactory. There were 55 positive cultures for a percentage of 16.4 percent positive. Patients with positive cultures were referred to the Richland County Health Department for treatment with erythromycin 500 mg., four times a day for seven days. Unfortunately, follow-up cultures could not be obtained. This must be done in future studies to anticipate the incidence of potentially infected infants.

Fifty-one patients were interviewed to determine their sexual contacts. There was a total of 44 male contacts identified of which 29 could be found and tested for *C. trachomatis*. There were eight positive cultures obtained for a positive percentage of 27.6 percent. The patient contacts who were positive were treated with tetracycline 500 mg., four times a day for seven days.

The newborn nursery at Richland Memorial Hospital was notified of each pregnant woman with a positive culture for *C. trachomatis*, either treated or untreated, in time for delivery. Observation or treatment and follow-up was planned to determine the incidence of pneumonia and conjunctivitis in the infant population. Follow-up is extremely important since existing nasopharyngeal colonization could progress to pneumonia.

* From the South Carolina Department of Health and Environmental Control (Drs. Gabel and Dowda, Mr. Shearin, and Mr. Arvelo) and the University of South Carolina School of Medicine and Richland Memorial Hospital (Dr. Bacon), Columbia, S. C.

** Address correspondence to Dr. Gabel at the South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, S. C. 29201.

CHLAMYDIA TRACHOMATIS

Infection with *Neisseria gonorrhoeae* has long been associated with conjunctivitis and possible meningitis, arthritis, and sepsis in the newborn as well as postpartum pelvic infection in the mother. In our hospital, all pregnant women are cultured for gonorrhea during their initial prenatal visit. Although the prevalence of gonococcal infection was not evaluated by our study, between February 8, 1984, and July 10, 1984, the entire prenatal population, in these same clinics (618 women), was cultured for gonorrhea at their initial visit by the clinic staff. There were 22 positive cultures for an incidence of 3.6 percent.

Noting the fact that in our sample population, 16.4 percent of the women had a positive chlamydia culture, compared to 3.6 percent with a positive gonorrhea culture in a similar population; we believe that culturing and treating pregnant women who attend our clinics and their sexual partners for the presence of *C. trachomatis* would be a wise decision.

With the previously stated incidence of chlamydial infection in pregnant women, it is also recommended that in each health care setting providing prenatal care, a determination of the prevalence of *C. trachomatis* be made. Based on that information, serious consideration should be given to including the detection of *C. trachomatis* in at least the initial prenatal workup. Testing may be made more palatable due to the advent of less costly, rapid, diagnostic tests. This action would be especially appropriate where good liaison exists with the local public health department for patient and contact follow-up. □

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137TH ANNUAL MEETING AND SCIENTIFIC ASSEMBLY - APRIL 24-28, 1985 - CHARLESTON, SC

SCMA TAKES SWIFT ACTION....

...to address the urgent issue of the South Carolina Supreme Court decision which declared the State Board of Medical Examiners as unconstitutionally constituted, on the basis of the fact that members of the Disciplinary Commission and possibly physician members of the Board itself were required to be members of the SCMA. Although this decision was unclear on several matters, such as the legality of past actions of the Board, on the advice of the State Attorney General, the Board of Medical Examiners ceased all activities scheduled for the week of April 24-28 and thereafter.

During meetings in Charleston, the SCMA Board of Directors approved a Resolution supporting a re-hearing of the Supreme Court's decision. This Resolution was hand-delivered to the Attorney General's office on Saturday afternoon, April 27.

At the same time, a plan for legislative action was considered by the Board which they voted to support. This plan outlined an election process by which members of the Board -- and members of the Disciplinary Commission -- would be nominated and elected by licensed physicians in the respective Congressional Districts, or by licensed physicians statewide, in the case of the At Large position on the Board. This position of support was communicated to Governor Richard W. Riley from Charleston.

In addition, then President-Elect *Leonard W. Douglas, M.D.*, requested the Governor to appoint an Interim Board of Medical Examiners to deal with the pressing matters of licensing new physicians and pending disciplinary actions.

Dr. Douglas, in reporting these developments to the SCMA House of Delegates on Sunday, April 28, said *"I would call your attention to the fact that the SCMA was in a position to act promptly to address this urgent issue. There is no other group in this state which could have done so for the medical profession. I ask that you return to your communities, discuss this with our members, particularly point out to the non-members in your community the extreme importance of their membership in the SCMA. It is this type action on the part of the entire physician population in this state which underlines the importance of a unified medical community."*

AN ESTIMATED 500 PHYSICIANS....

...attended the 137th Annual Meeting, setting records for participation in CME activities, Association business and social functions. Reports received by SCMA staff indicate the CME Committee, under the Chairmanship of *James M. Long, III, M. D.*, deserves congratulations for a job well done. *SCMA Speaker of the House, Walter J. Roberts, Jr., M. D.*, praised the Reference Committees and their Chairmen, for seeing that the business of the House of Delegates ran smoothly. See inside for details and highlights of the week's activities.

121st PRESIDENT OF THE SCMA....

...*Leonard Walter Douglas, M. D.*, of Belton, South Carolina, was installed during impressive ceremonies at the President's Banquet on Saturday evening, April 27. In his inaugural address to members and guests, Dr. Douglas issued two challenges to South Carolina physicians -- to maintain their professionalism and ethical base, and to recognize their social responsibilities as members of their communities.

OTHER OFFICERS AND MEMBERS OF THE BOARD....

...elected on Sunday, April 28 are

J. Gavin Appleby, M.D., President-Elect. Dr. Appleby has served as Secretary of the Association, as well as Vice Speaker and Speaker of the House. He is a family practitioner in St. George.

John W. Simmons, M. D., Secretary. Dr. Simmons is a family practitioner from Spartanburg. He has served the SCMA previously as First and Second Vice President.

Thomas C. Rowland, Jr., M. D., Treasurer. Dr. Rowland was re-elected to this position after having served the past year. He is in the private practice of OB/GYN in Columbia.

John C. Hawk, III, M. D., Charleston, Trustee, District One

Daniel W. Brake, M. D., Charleston, Trustee, District One

Richard M. Carter, M. D., Greenwood, Trustee, District Three

Terry L. Dodge, M. D., Rock Hill, Trustee, District Five

S. Perry Davis, M. D., Pinewood, Trustee, District 7 (Re-elected)

J. Sidney Fulmer, M. D., Spartanburg, Trustee, District 9 (Re-elected)

Donald G. Kilgore, Jr., M. D., Greenville, AMA Delegate (effective 1/1/86)

Randolph D. Smoak, Jr., M. D., Orangeburg, AMA Alternate Delegate (re-elected)

Walter G. Roberts, Jr., M. D., Columbia, Speaker of the House (re-elected)

O. Marion Burton, M. D., Anderson, Vice Speaker of the House (re-elected)

SPECIAL AWARDS WERE PRESENTED....

...during the President's Banquet on Saturday to:

Donald G. Kilgore, Jr., M. D., Greenville, recipient of the A. H. Robins' Physician's Award for Community Service, and

C. Tucker Weston, M.D., Columbia, recipient of the 1985 President's Award, for his outstanding contributions to, and achievements in, the field of medicine. In making the presentation, Kenneth N. Owens, M.D., said that "Dr. Weston's devotion to family, colleagues, and his medical practice, coupled with his natural ability in many diverse leadership positions distinguish this native South Carolinian as a truly great American."

SPECIAL AWARDS (CONTINUED)...

...Special Awards presented during the closing session of the House of Sunday include

The Thomas A. and Shirley W. Roe Award, for the best article published in *The Journal of the South Carolina Medical Association* in 1984 to *Edward L. Hay, M. D.*, and *J. Stewart Haskin, Jr., M. D.*, for their article entitled "Intraarticular Fractures of the Hand: Careful Scrutiny is Advised."

The SCMA Journalism Award for the best newspaper article on a medically related topic published in 1984 to *Mobashir (Moby) Salahuddin*, medical writer for *The State* newspaper in Columbia. He received this award for his three part series of articles titled "Cost of Care for the Poor Poses Statewide Problem."

THE SCMA COUNCIL BECAME THE BOARD OF TRUSTEES....

...upon the adoption of the new Constitution considered by the House in 1984 and postponed for final action at this year's Annual Meeting. Following adjournment of the House of Delegates, the new Board of Trustees met for the purpose of re-organizing, and elected the following:

Charles R. Duncan, Jr., M. D., Greenville, Trustee, Fourth District,
CHAIRMAN OF THE BOARD

William H. Hester, M. D., Florence, Trustee, Sixth District, VICE CHAIRMAN
OF THE BOARD

Daniel W. Brake, M.D., Charleston, Trustee, First District, EXECUTIVE COMMITTEE
MEMBER AT LARGE

John C. Hawk, III, M. D., Charleston, Trustee, First District, CLERK

BOARD MEMBERS OF SUBSIDIARY AND AFFILIATES....

...elected or appointed include:

Frank Martin, M. D., *John C. Rheney, Jr., M. D.*, *Gerald Wilson, M. D.*, to
the Board of the SCMA Members' Insurance Trust;

Charles R. Duncan, Jr., M. D.; *John B. Johnston, M. D.*; *John W. Simmons,*
M. D.; *Edward L. Proctor, M. D.*; to the Board of the S. C. Medical Care
Foundation; and

Kenneth N. Owens, M. D., and *Charles R. Griffin, M. D.*, to the S. C. Medical
Building Corporation Board of Directors.

COURY SAYS "STOP APOLOGIZING....

...for what we are doing in medicine." John W. Coury, M. D., Chairman of the AMA Board of Trustees told SCMA delegates assembled in Charleston about the problems organized medicine is facing in this country. He stated that everyone has the impression that the cost of medical care in America is the highest in the world. "Let me tell you," he said, "our cost of medicine is no more expensive than any place else in the world." His final plea to delegates was "to continue (to practice) quality medicine."

RESOLUTION REGARDING DUMPING OF TOXIC WASTE....

...submitted by the Sumter-Clarendon Medical Society was adopted by the House of Delegates. It reads as follows: *"RESOLVED, that we are opposed to the dumping of toxic waste from other states into the state of South Carolina, and in particular, we are opposed to the further operation of a toxic waste dump at Pinewood, South Carolina."*

The House also adopted a Second Medical District Resolution *"that the South Carolina Medical Association endorse and support legislation requiring mandatory seat belt use in South Carolina."*

Another Second Medical District Resolution was amended and adopted which calls on the SCMA to petition *"the Governor of South Carolina and the S. C. State Legislature to enact legislation assuring that a greater percentage of the awards in malpractice suits be directed toward the injured party, and specifically that the Legislature enact laws to determine a cap on contingency payments."*

The SCMA Board of Trustees will be considering the appropriate actions necessary to implement the intent of these Resolutions, as well as others adopted by the House.

D. STROTHER POPE, M. D. DOCTOR OF THE DAY ROOM....

...The South Carolina legislature recently adopted a Resolution to name the Doctor of the Day Room in the State House in honor of *D. Strother Pope, M. D.*, of Columbia. Dr. Pope was instrumental in the establishment of the Doctor of the Day program in the Legislature, *"to administer to the medical needs and emergencies of the members of the General Assembly, their clerks and attaches, and visitors."* The SCMA expresses special appreciation to The Honorable Jennings McAbee of McCormick, who spearheaded the Resolution. Dr. Pope recently underwent hip replacement surgery and is now recovering at home.

A Doctor of the Day Nurse, *Lt. Colonel Hazel A. Johnson, R. N.*, was recently installed as President of the Palmetto-Columbia Reserve Officers Association. Colonel Johnson is the first woman to be elected President of this organization. The SCMA sends congratulations to Colonel Johnson, a valuable member of the Doctor of the Day program.

CAPSULES....

The following loyal SCMA members were recently awarded honorary membership status in the SCMA and AMA: *George R. Dawson, Jr., M. D.; James G. Jeans, M. D.; Lawrence L. Hester, Jr., M. D.; Abraham M. Robinson, M. D.; and Lawrence Crowl, M. D.*

The SCMA Board of Directors has endorsed the candidacy of *Robert Taylor, M. D.*, as a candidate for the Presidency of the American Academy of Family Practice.

**** WATCH FOR PICTORIAL HIGHLIGHTS OF THE ANNUAL MEETING IN**

AN UPCOMING ISSUE OF THE JOURNAL **

USE OF DEXTROAMPHETAMINE IN EPILEPSY

J. GAVIN APPLEBY, M.D.*

My interest in this subject began some four years ago when I was treating three problem patients with Grand Mal Epilepsy.

CASE 1. One patient was a 35-year-old white female who had had grand mal seizures since age thirteen. She was well controlled on several standard epileptic medicines including dilantin and phenobarbital, with the exception of having developed nocturnal seizures. These seizures were unresponsive to any of the commonly used anti-epileptics. They were considerably worrisome because she worked in a sewing room and the seizures occurred late in the sleep pattern, usually within one hour of awakening in the mornings. To have a grand mal seizure at that time of day pretty well obliterated the day as far as work was concerned. The frequency of these seizures threatened her vocation and created considerable strain and tension for her.

CASE 2. The second patient was a 32-year-old white male with almost identical history. He was a diesel mechanic and a seizure occurring early in the morning just prior to awakening would cause him to lose a day's work also. His nocturnal seizures also became frequent and could not be controlled by any standard medication, including dilantin and phenobarbital.

CASE 3. The third patient was a 12-year-old white female who started having petit mal seizures at age three. These continued with poor control with usual medications until puberty at which time she developed complex seizures. The neurologist and I tried multiple preparations on this patient with only fair success and in mid-1984 her complex seizures became more frequent and more disabling.

THERAPY

All three of these patients responded beautifully to Dextroamphetamine. The two nocturnal seizure cases were given a single bedtime dose of 5

mg. of Dextroamphetamine. This small dose completely controlled the nocturnal seizures in both cases. They have now been on this drug for some years with no untold side effects. This corresponds with Samuel Livingston, M.D.'s study in Boston which also did not show any long term side effects and did not observe the occurrence of any lymphadenopathy or Hodgkins Disease.¹

The young lady was given a dose of 10 mg. of Dextroamphetamine in the morning and 10 mg. of Dextroamphetamine in the evening. This was in addition to Zarontin and Clonopin. The addition of Dextroamphetamine in her case made a remarkable improvement. She has returned to a fairly normal school participation. The change in her personality has been remarkable and she has shown none of the probable side effects of anorexia or insomnia.

DISCUSSION

G. A. King from the Department of Pharmacology, University of Toronto, demonstrated in 1980 that Dextroamphetamine has a definite pharmacological action which should help control petit mal epilepsy.² Samuel Livingston in his experience with many, many patients in Boston reported, and I quote, "In our experience, the most efficacious drug for the control of sleep (nocturnal) seizures, which are frequently resistant to the standard antiepileptic agents, is dextroamphetamine."

These three patients affirm the works of Livingston and King. The change in personalities and general wellbeing of these patients has been remarkable. There is a definite psychological improvement which in my estimation is independent of control of the epilepsy. Apparently there is a psychopharmacological action of dextroamphetamine in these type cases which not only improves the seizure pattern but definitely also improves the general wellbeing, the general initiative of the patient and makes for a more pleasant existence for the patient.

I have not noticed any tolerance developing to the drug with my patients whose history now extends to four years.

* 202 Gavin Street, St. George, S. C. 29477.

SUMMARY

There is a legitimate use of dextroamphetamine in the treatment of epilepsy. Experience of Livingston out of Boston has suggested this for some time. I have presented three cases of difficult-to-manage forms of epilepsy which have responded quite nicely to this medication. The side effects are extremely minimal and no long term toxic effects have been observed.

It should be noted that dextroamphetamine is a closely controlled drug. Its use requires permission, on a patient-by-patient basis, from the State Board of Medical Examiners. Thus, although this drug appears to be valuable in selected circumstances, its widespread usage should be strongly discouraged. □

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BACTEREMIC PNEUMOCOCCAL PNEUMONIA: RELATIONSHIP OF INITIAL ANTIMICROBIAL THERAPY TO OUTCOME*

MARY Q. BURKE, M.D.

DEBORAH SCHOFIELD, M.D.

KENNETH L. REYNOLDS, D.V.M.

CHARLES S. BRYAN, M.D.**

Recommended antimicrobial therapy of pneumococcal pneumonia, in the absence of extrapulmonary infection or penicillin allergy, consists of small doses of penicillin.^{1, 2} It is commonly taught that use of larger doses of penicillin or of antimicrobial agents possessing a broader spectrum of activity promotes colonization and superinfection by additional pathogens.³⁻⁵ Despite considerable interest in pneumococcal disease, the problem of antimicrobial therapy has not been extensively reviewed in recent years.

The apparent increase in both frequency and diversity of pneumonias due to pathogens other than the pneumococcus makes relatively broad spectrum initial therapy of pneumonia, prior to availability of culture results, increasingly desirable for certain patients.⁶⁻⁷ This is especially the case when initial studies such as microscopic examination of Gram-stained smears of sputum are non-diagnostic. A prospective study designed to re-examine the relationship of initial antimicrobial therapy of severe pneumococcal pneumonia to outcome would be of value. However, such a study is unlikely to take place, at least in the near future, for a variety of reasons. We report here a retrospective analysis of the relationship of initial antimicrobial therapy to outcome for all patients with bacteremic pneumococcal pneumonia encountered in one metropolitan area over a five-year period.

METHODS

Between January 1, 1977 and December 31, 1981, surveillance of all documented episodes of

bacteremia in the four major hospitals of Columbia, South Carolina was carried out by methods described previously.^{8, 9} The presence of pneumonia was determined by new infiltrates on chest x-rays.

Deaths were attributed to pneumococcal disease if occurring within ten days of the last positive blood cultures for *S. pneumoniae* and if no other and more obvious explanations for death were present in the hospital records. Secondary pneumonias were defined either by the recurrence of fever after one or more afebrile days associated with increasing symptoms and signs of lower respiratory tract disease, increasing sputum purulence, and new infiltrates on chest x-rays⁴; by the occurrence of second episodes of bacteremia attributed to lower respiratory tract infection; or by the combination of necrotizing pneumonia and isolation of other pathogens from lung tissue at autopsy.

Initial antimicrobial therapy was defined on the basis of regimens used within 24 hours of the first positive blood cultures. Narrow spectrum therapy was defined as the use of penicillin as the sole agent. Moderately broad spectrum therapy was defined as regimens containing an aminoglycoside antibiotic, a tetracycline, or chloramphenicol. Recognizing the arbitrariness of such definitions in some instances, we took into account the wide variety of penicillin regimens employed, the lack of use of any of the newer, so-called "third generation" cephalosporin antibiotics in these patients; and the customary use of aminoglycoside antibiotics only in combination with other agents. We reviewed the following determinants of adverse prognosis from pneumococcal disease: advanced age, presence of chronic heart or lung disease, presence of other underlying diseases considered to be fatal (death anticipated

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during hospitalization) or ultimately fatal (death anticipated within five years)¹⁰; major involvement of more than one lobe on chest x-rays; total white blood count less than 5,000/cu mm; shock, defined by systolic blood pressure below 100 mm Hg accompanied by clinical hallmarks of shock such as delirium and oliguria; and acquisition of pneumococcal bacteremia while in the hospital, defined by the first positive blood cultures having been obtained on or after the third hospital day.¹¹⁻¹³

Comparison of therapy groups was carried out by the chi-square test or Student's t-test.

RESULTS

During the five-year study period, 232 documented episodes of pneumococcal bacteremia occurred among 300,547 patients (exclusive of stillbirths) who were treated and discharged at these four hospitals. Of these, 167 patients had new infiltrates on chest x-rays and were included in this analysis.

Overall mortality was 20 percent based on deaths attributed to pneumococcal disease and 24 percent based on deaths due to all causes. Mortality was greater for the 23 hospital-acquired episodes of bacteremic pneumococcal pneumonia compared to the 144 community-acquired episodes (for deaths attributed to pneumococcal disease, 39 percent vs 17 percent, $P < 0.02$ and for all deaths, 50 percent vs 20 percent, $P < 0.01$). Both patients with rapidly fatal underlying diseases died from pneumococcal disease. Mortality due to pneumococcal disease was 27 percent for the 34 patients with ultimately fatal underlying diseases and 17 percent for the 131 patients with nonfatal underlying conditions. Mortality was directly related to age, with only one death occurring among patients under 21 years of age (Fig 1).

Relationship of Antimicrobial Therapy to Outcome

Patients under age 21 were excluded from this analysis because of their low mortality rate and patients with either meningitis or endocarditis were excluded because of their unique therapy requirements. There remained for analysis 128 patients, aged 21 to 100, with bacteremic pneumococcal pneumonia unaccompanied by meningitis or endocarditis. Overall mortality was 25 percent for these 128 patients. Eighteen of the 32

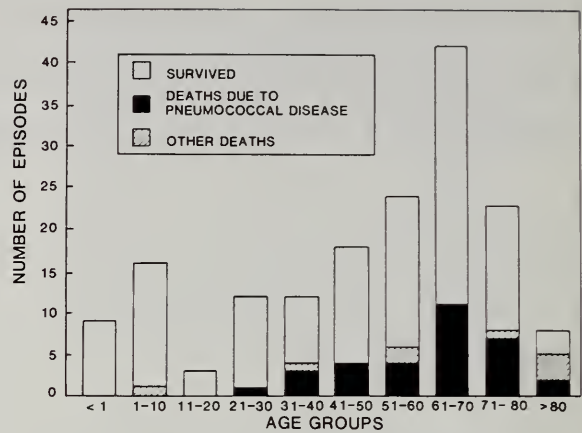


FIGURE 1. Age distribution of 167 patients with bacteremic pneumococcal pneumonia and associated mortality attributed to pneumococcal disease (solid bars) and to other causes (shaded bars).

deaths occurred by the end of the third day after positive blood cultures were first obtained.

All but six of these 128 patients received antimicrobial therapy within 24 hours of the first positive blood cultures (Table 1). Penicillin preparations were the most frequently used agents for initial therapy. Twelve patients received procaine penicillin G intramuscularly, which in all but one instance was administered as 600,000 units every 12 hours. One patient received crystalline penicillin G intramuscularly and one patient received phenoxymethyl penicillin V by mouth. Crystalline penicillin G was given intravenously to 44 patients by 22 different dosing regimens (Table 2).

Patients who received broad spectrum initial therapy experienced greater mortality compared to patients who received other regimens (Table 3). Age distributions and the numbers of lobes involved on chest x-rays were similar among the three therapy groups. However, compared to patients in other therapy groups, patients who received broad spectrum initial therapy were more likely to have had either fatal or ultimately fatal underlying disease or chronic heart or lung disease (51 percent vs 31 percent, $P < 0.05$); to have had hospital-acquired rather than community-acquired pneumococcal bacteremia (24 percent vs 7 percent, $P < 0.01$); to have had leukopenia (29 percent vs 11 percent, $P < 0.025$); and to have been in shock (29 percent vs 9 percent, $P < 0.005$). In addition, patients who received broad spectrum initial therapy tended to have lower absolute

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TABLE 1. Initial Antimicrobial Therapy Regimens

Regimen	No. of Patients
<u>Narrow Spectrum Therapy</u>	
Penicillin V or G (< 10 million units/day)	20
Penicillin G (≥ 10 million units/day)	11
<u>Moderately Broad Spectrum Therapy</u>	
Beta-lactam antibiotic other than penicillin*	41
Erythromycin or clindamycin, with or without a beta-lactam antibiotic	9
<u>Broad Spectrum Therapy</u>	
Aminoglycoside antibiotic plus additional antibiotic†	34
Aminoglycoside antibiotic alone	4
Tetracycline plus beta-lactam antibiotic	2
Chloramphenicol plus beta-lactam antibiotic	1

*Of these patients, 34 received a single beta-lactam antibiotic: a cephalosporin (22 patients); ampicillin or amoxicillin (9); or an antistaphylococcal penicillin (3). Seven patients received two beta-lactam antibiotics.

†These 34 patients received 39 additional antibiotics: penicillin G (13 patients); a cephalosporin (13); ampicillin (4); an antipseudomonal penicillin (3); clindamycin (3); erythromycin (2); and an antistaphylococcal penicillin (1).

TABLE 2. Dosing Regimens of Crystalline Penicillin G in 44 Patients

Unit Dose	<u>Interval Between Doses</u>						
	2 Hours	3 Hours	4 Hours	6 Hours	8 Hours	12 Hours	24 Hours
	<u>No. of Patients</u>						
400,000 units			1				
600,000 units			2	2		1	
1 million units		1	2	1			
1.2 million units						1	
1.6 million units			1				
2 million units	3		12	4		1	
2.5 million units			2				
3 million units		2					
4 million units			1	1			
5 million units				1			
6 million units				1	1	2	1

TABLE 3. Outcome in 128 Episodes of Bacteremic Pneumococcal Pneumonia According to Initial Antimicrobial Therapy

Initial Antimicrobial Therapy* (No. of Patients)	Deaths Attributed to Pneumococcal Infection*	Deaths Attributed to Other Causes
<u>No. of Deaths (% Mortality)</u>		
Narrow spectrum (31)	3 (9.7)	2 (6.5)
Moderately broad spectrum (50)	4 (8.0)	5 (10.0)
Broad spectrum (41)	13 (31.7)†	2 (4.9)
None (6)	3 (50.0)	0 (---)

*For definitions, see Methods.

†Compared to narrow spectrum and moderately broad spectrum therapy groups combined, $P < 0.005$.

granulocyte counts compared to patients in the other therapy groups (mean 7,041/cu mm \pm 1,051 SEM vs 12,415/cu mm \pm 843 SEM, $P < 0.001$). Comparison of the duration of hospitalization among the therapy groups, both for survivors and for patients who died, revealed no significant differences. One well-defined episode of secondary pneumonia occurred in each of the three therapy groups. Only two late deaths occurred among patients who received broad spectrum initial therapy (Table 3); both of these deaths were due primarily to underlying diseases.

Fourteen of the patients who received moderately broad spectrum initial therapy and 19 of the patients who received broad spectrum initial therapy were subsequently given narrow spectrum therapy, presumably on the basis of results of cultures or of response to therapy. Due to the varying durations of initial therapy for these patients and to the diversity of regimens employed, no attempt was made to compare outcomes for these patients with those of patients for whom initial therapy was not subsequently altered.

Four patients who received narrow spectrum initial therapy were subsequently given broad spectrum therapy. Review of patient records indicated that in three of these instances, the decision to change to broad spectrum therapy occurred on or prior to the third day of hospitalization. These decisions may have been based on lack of early response to therapy or on unavailability of bacteriology results in these three patients, all of whom survived without superinfection. In the fourth patient, gentamicin and cephalothin were added on the seventh day after onset of pneumococcal bacteremia; *Proteus mirabilis* was isolated from subsequent sputum cultures, but the significance of this isolate was unclear.

DISCUSSION

No large-scale, randomized, prospective comparative trials of antibiotic regimens for bacteremic pneumococcal pneumonia have been conducted. Such a trial would be difficult to conduct for several reasons. First, adults with bacteremic pneumococcal pneumonia tend to be acutely ill, whereas trials of antibiotics tend to concentrate on less seriously ill patients. Thus in a recent prospective, randomized study of 100 patients with suspected pneumococcal pneumonia, only five were later determined to have positive blood cultures.¹⁴ Second, bacteremic pneumococ-

cal pneumonia is a relatively infrequent event at individual hospitals. For instance, Dans *et al.* found that only seven of 147 patients with pneumonia studied at Johns Hopkins Hospital during 1979-1980 had bacteremia.¹⁵ Finally, although retrospective surveys have failed to demonstrate therapeutic superiority of one or another agent active against pneumococcus,¹¹ ethical concerns would still have to be overcome. It has been shown that broad spectrum therapy promotes colonization of the tracheobronchial mucosa by potential secondary pathogens³⁻⁵ and therefore the use of broad spectrum therapy for patients in whom examination of Gram-stained smears of sputum or other studies clearly indicate pneumococcal disease could be questioned.

In the present study, we found that only two of 41 patients who received broad spectrum initial antimicrobial therapy experienced late deaths, and that neither of these two deaths was due to secondary infection. Well-defined secondary pneumonia did not correlate with initial antimicrobial therapy. We emphasize that case definition of secondary pneumonia can be extremely difficult and also that we made no attempt to determine the prevalence of tracheobronchial colonization by potential secondary pathogens. These data do not challenge the concept that broad spectrum therapy promotes such colonization. These observations are descriptive, and no attempt was made to determine colonization rates systematically. On balance, however, these data may provide a measure of reassurance to physicians who prescribe broad-spectrum initial therapy to seriously ill patients with pneumonia when initial studies such as microscopic examination of Gram-stained smears of sputum are inconclusive.¹⁶ The subsequent isolation of *S. pneumoniae* from blood cultures should usually prompt a change to narrow spectrum therapy with penicillin G.

Several observations warrant further comment. First, we found that excess mortality among patients who received broad spectrum initial therapy did not correlate with death from secondary pneumonia, but instead correlated with more severe underlying disease and more overwhelming pneumococcal disease among these patients. The tendency of physicians to use "drugs of fear"¹⁷ for critically-ill patients may explain many instances of broad-spectrum initial therapy.

Second, these data confirm the value of ongoing

review of antibiotic usage at individual hospitals. The occasional use of aminoglycoside antibiotics as sole initial therapy for pneumonia should be discouraged, since these agents have little or no activity against the pneumococcus at clinically achievable concentrations.¹⁸

Third, we found that the doses of penicillin used in clinical practice nearly always exceed the small doses usually recommended for pneumococcal pneumonia,¹⁻² and that penicillin G is more frequently administered intravenously than intramuscularly or orally. The wide variety of intravenous penicillin G dosing regimens observed both in the present study and also by Dans *et al.*¹⁵ may reflect a paucity of published guidelines. Intramuscular procaine penicillin G remains the most cost-effective parenteral therapy for uncomplicated pneumococcal pneumonia. Various authors tend to recommend identical doses of penicillin G whether given intramuscularly or intravenously,^{1, 19} despite the substantial pharmacokinetic differences between administration of procaine penicillin G intramuscularly and administration of crystalline penicillin G intravenously.

Finally, these observations confirm once more both the continued high mortality exacted by bacteremic pneumococcal pneumonia and the existence of certain risk factors to mortality such as age, underlying disease, leukopenia, and shock. Our finding that 56 percent of deaths among these patients occurred within three days of the first positive blood cultures supports the conclusion reached by Austrian and Gold¹¹ that antibiotics have not reduced the early mortality due to bacteremic pneumococcal pneumonia, emphasizing

again the potential value of pneumococcal polysaccharide vaccine for patients at special risk such as the elderly.²⁰

SUMMARY

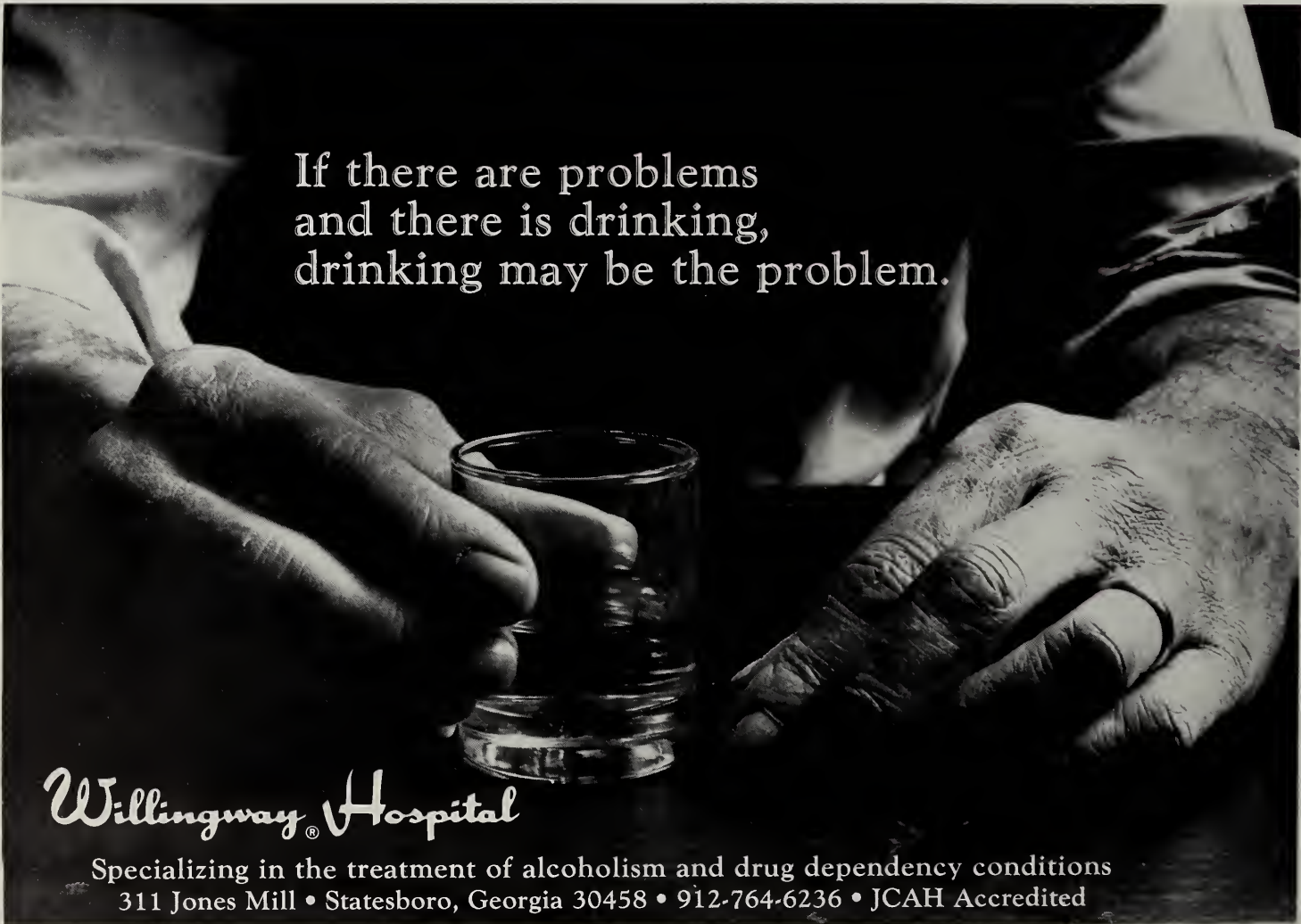
Although it is frequently stated that broad spectrum antimicrobial therapy of pneumococcal pneumonia predisposes to secondary infection, this issue has not been extensively examined in recent years. We reviewed 128 cases of bacteremic pneumococcal pneumonia in adults with emphasis on relationship of initial therapy to outcome. Patients who received broad spectrum initial therapy — defined as a regimen containing an aminoglycoside antibiotic, a tetracycline, or chloramphenicol — experienced greater mortality from pneumococcal disease compared to other patients. However, these patients also had more severe pneumococcal disease and more severe underlying diseases compared to the other patients. Choice of initial therapy did not correlate with excess late mortality, secondary pneumonias, or prolonged hospitalization.

These observations should provide some measure of reassurance to physicians faced with the problem of providing optimum initial therapy for pneumonia when studies such as examination of Gram-stained smears of sputum are non-diagnostic. If initial therapy is broad-spectrum, however, prudence continues to dictate that therapy should be simplified (for example, to low-dose penicillin) when results of cultures and observation of the clinical course confirm the diagnosis of pneumococcal pneumonia. These data further indicate that pneumococcal bacteremia remains an important clinical problem. □

PNEUMOCOCCAL PNEUMONIA

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Editorials

FIXED FEES: A DISTANT MIRROR

The call for fixed, uniform fees for physicians' services now comes not only from outside agencies over which we have little if any control (such as Medicare) but also from many new and growing practice arrangements (such as HMOs and IPAs). The insistence that participating physicians must abide by these fee schedules threatens our sense of autonomy. While this trend may indeed represent a palpable departure from our recent past, it is of some interest to note that our predecessors labored under similar arrangements.

On Monday, March 13, 1854 the physicians of Columbia met in our capital city's town hall to organize a medical society. Prominent among the deliberations was the proposal of a uniform fee bill (Table). The constitution made clear the importance of the fee bill:

"The members of the Society practising in Columbia shall deem it a point of honor to adhere to the Fee Bill adopted by it, and under no circumstances attend individuals, families or plantations by yearly contract, as that mode of practice never gives satisfaction to either party."

The authors of the fee bill stated that it was clearly not intended "to restrain the Physician in the exercise of charity or liberality towards patients in limited circumstances."

Once again, we have merely re-discovered old inventions!

— CSB

FEE BILL — MEDICAL SOCIETY OF COLUMBIA, S. C., 1854

TOWN PRACTICE.

For each visit in the day,	\$1	
" Prescription,	1	
" Requested visit after dark,	2	
" " " after 10 o'clock, P.M.,	5	
" Rising from bed and prescribing at home,	2	
" Detention per hour,	2	
" Being kept up all night,	10 to	15
" Consultation,	10	
" Each subsequent visit, (consulting Physician,)	2	
" Prescription at office (ordinary cases),	1	
" Medical advice, or opinions given by letter or otherwise, according to the importance of the case,	5 to	10
" Certificate of Insurance, to be paid by the agent,	2 to	5
" Certificate of non-liability to Jury, Patrol or Militia duty—or freedom from Taxes,	2 to	5
" Certificate of examination of a Lunatic,	5	
" Vaccination,	1	
" Administering Chloroform, (medically, by inhalation,)	2	
" Applying electro-magnetism,	2	
" Applying Leeches, (exclusive of cost,)	2	
" Opinion of soundness or unsoundness of a negro,	5 to	20

COUNTRY PRACTICE.

For riding out of Town in the day, each mile, measuring from the State House,	\$1	
" Riding out of Town at night, each mile,	2	
" Crossing Bridge or Ferry,	1	
" Prescription,	1	
" Surgical and Obstetrical cases, additional charges to be made in accordance with the rates established for the Town.		
" Vaccination on plantation, mileage, and for each,	1	

SURGERY.

For Venesection,	\$1	
" Arteriotomy or bleeding in the Jugular Vein,	3 to	5
" Cupping,	2	
" Extracting tooth at office,	1	
" Introducing Catheter or Bougie (first time),	5	
" Each subsequent introduction,	2	
" Dressing ulcers or wounds,	1 to	\$5
" Opening Abscess,	1 to	5
" Gonorrhœa, (in advance,)	10 to	30
" Syphilis, (simple cases,) (in advance,)	20	
" Chronic case, in proportion to treatment required.		
" Treating Stricture,	20 to	40

" Issue or Seton,	2	" " " Lower Jaw,	10 to 20
" Use of speculum uteri vel ani, (first time,)	5	" " " Clavicle,	15 to 25
" Each subsequent introduction,	2	" Reducing dislocation of the Thigh,	20 to 60
" Examination per vaginam,	5	" " " Knee or Ankle,	15 to 30
" Lancing gums,	1	" " " Shoulder, Elbow, or Wrist,	10 to 30
" Fitting truss,	2 to 5	" " " Smaller Joints,	5 to 10
" Reducing Prolapsus Ani or Uteri,	5 to 20	" Trephining,	40 to 80
" Operation for Hydrocele,	15 to 25	" Paracentesis of Abdomen, Thorax or Bladder,	10 to 25
" Excising incarnated toe nail,	5 to 20	" Extirpating Cancerous lip,	20 to 40
For Phymosis and Paraphymosis,	10	" Operating for Hare Lip,	20 to 40
" Lithotomy,	50 to 100	" Extirpating Tonsils,	10 to 50
" Important operations on the eye,	25 to 100	" Extirpating Tumors,	10 to 100
" Minor operations,	5 to 20	" Operation on Fistula in Ano vel Perinco,	20 to 40
" Amputation of the Breast,	20 to 100	" Extracting foreign substances from the body,	5 to 50
" " " Finger or Toe	5 to 25	For all other operations in Surgery in a relative proportion to the preceding.	
" " " Forearm, Arm, Leg or Thigh,	25 to 75		
" " " Shoulder Joint,	100		
" " " Hip Joint,	150		
" Reducing Hernia by taxis,	10 to 25		
" Operation for Hernia,	25 to 100		
" Operation for Bronchotomy, Œsophagotomy, or Tracheotomy,	20 to 100		
" Aneurismal Operations,	20 to 100		
" Extirpation of Polypi,	15 to 50		
" Tying wounded Arteries,	5 to 100		
" Setting Fractures of the Thigh or Leg,	20 to 30		
" " " Arm or Forearm,	15 to 25		

OBSTETRICS.

For cases of natural labour and first week's ordinary attendance,	\$25
" Complicated or instrumental cases,	30 to 100
For Advice to Midwife,	15
" Consultation in Midwifery,	15 to 30
" Extracting Placenta,	10 to 25
" Presence with Midwife, though not acting,	25

REFERENCE

1. Constitution, Code of Ethics, and Fee Bill of the Medical Society of Columbia, S. C., Established March 13, 1854 (Columbia: Steam-Power Press of R. W. Gibbes & Co., 1854).

PHILANTHROPIA AND PHILOTECHNIA

Dr. Joseph F. Boyle, president of the AMA, recently addressed the Columbia Medical Society and left behind some memorable thoughts. I came away with three salient points. First, we should face today's climate of economic uncertainty not with despair, but rather as a challenge. We must be willing to change course, when necessary, but we must not lose sight of our mission. Second, we should take pride in the overwhelming acceptance by American physicians of voluntary limits on fee increases. Are we not responding appropriately to the public mandate to contain costs? Finally, we should address the following question, both individually and collectively: "Are we going to be *professionals* or *pragmatists*?" The choice, Dr. Boyle reminded us, is ours alone to make.

There remains a problem of definition. What does it *mean* to be a professional, as opposed to a

pragmatist? In its common usage, the term "professional" has been diluted rather considerably over the years and now includes just about anyone who performs a specialized function. Your car salesman, your barber, even your waiter would like to be known as a "professional." The term has been discussed periodically in these pages, and the reflections several years ago by Dr. Leon Banov are particularly memorable. Dr. Banov reminded us that "the profession of medicine does not bestow value upon us; rather we should bestow value upon the medical profession."¹ But the lingering question remains: how is a profession *really* different from a trade?

Earlier in this century, as scientific medicine came into its own, the notion of professionalism in medicine was firmly embodied in the teaching and example of Sir William Osler. In the memora-

ble final paragraph of his last address, Osler evoked the legacy of Hippocrates: "*philanthropia* and *philotechnia* — the joy of working joined in each one to a true love of his brother." Professionals differ from tradesmen, in part, by virtue of love and compassion for those served. Osler noted that it was in this context that the word "philanthropy" was coined.²

In a sense, the term "professional" carries with it an elitist attitude: the specialist with his or her esoteric body of information is somehow superior to the uninformed layman.³ To expand upon Dr. Boyle's challenge, taking Osler's memory of Greek medicine into account, one can re-phrase the challenge: are we to be *philanthropic professionals* or *pragmatic tradesmen*?

I suggest that this issue is not a recent one, but rather exists as a constant, recurring tension throughout the history of medicine.

We, like Osler, embrace the Greek ideal of philanthropy in medicine. Ringing clearly in our collective consciousness is the statement that "where there is love of man, there is also love of the art." However, careful scrutiny of the medical practice of classical Greece undermines our glorification of its philanthropy. The late Dr. Ludwig Edelstein, foremost authority on the writings attributed to Hippocrates, concluded that the notion of "philanthropy" meant "no more than a certain friendliness of disposition, a kindness, as opposed to any misanthropic attitude."² Edelstein's comments on the prevailing attitudes during antiquity are sobering:

"As for the physician's motives in practicing medicine, he was engaged in it in order to make a living. Nor was there any conflict between his pecuniary interests and the exigencies of craftsmanship, as long as he remembered that love of money, of easy success, should not induce him to act without regard for the benefit of the patient, or, to speak with Ruskin, that the good workman rarely thinks first of his pay, and that the knack of getting well paid does not always go with the ability to do the work well. If he learned to forget personal advantage for the sake of doing the right thing, he had, in his opinion, done all that was necessary."⁴

Evidence indicates that other Greeks, including Plato, were quite comfortable with this concept of

the physicians' motives.

Clearly, medical practice cannot be pure philanthropy in the modern sense of giving freely with the expectation of no material reward in return. Physicians, too, must earn a living — and indeed the problem of earning a living will intensify as the number of physicians increases through the remainder of this century. We should point out that even Osler enjoyed a busy and quite lucrative practice, and at times drew criticism from his patients for what was felt to be a less-than-sympathetic demeanor.⁵

The challenge, as I see it, is to somehow combine philanthropy (in the modern sense) with economic reality. We should recall those anxious moments when, as sweaty-palmed youths, we were asked by medical school admissions committees: "Why do you *really* want to be a doctor?" Most of us responded with some variation of a familiar theme: "Sir, I like science and I want to help people." In solitude, we should periodically retreat to those moments and ask ourselves whether we remain true to those ideals.

In South Carolina, our profession recently received favorable publicity from a concept proposed by three Charleston nephrologists.⁶ Drs. George E. Malanos, W. Arthur Smith, and C. Jerry Owens proposed a private dialysis center which would create from its profits an indigent care fund. This fund would then be used to sustain the lives of persons unable to afford this expensive procedure. This example should inspire all of us to seek ways, within the limits of our own financial needs and resources, to combine charity with the practice of medicine. *Philanthropia* and *philotechnia*! In times of uncertainty, it helps to keep one's macular vision firmly on the mark!

— CSB

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3. Professionalism and the quality of medical care (editorial). South Med J 77: 1071-1072, 1984.
4. Edelstein L: The professional ethics of the Greek physician. Bull Hist Med 30: 391-419, 1956.
5. Harrel GT: Osler's practice. Bull Hist Med 47: 545-568, 1973.
6. Inspired physicians (editorial). The State (Columbia, S. C.), February 2, 1985, p 12-A.

LETTERS TO THE EDITOR

To The Editor:

I am enclosing a letter of January 15, 1985 from Senator Verne Smith. It has been brought to Senator Smith's attention that there has been some delay in having physicians complete their portion of certain death certificates. The problems as a result of this are evident.

As the voice of organized medicine in South Carolina, I thought that you may be able to assist with bringing to the attention of our doctors some of the problems that this can cause families, funeral directors, creditors and others. Naturally, the Board can and will take action in specific cases; but the most beneficial resolution to this problem is the one that Senator Smith has suggested of preventing the delay in the first place.

Let's pool our efforts and get behind this problem and see if we can get it resolved.

You know that the Board of Medical Examiners stands ready to be of any assistance possible and please call me for any cooperative effort or thoughts that you feel would be appropriate.

J. Ernest Lathem, M.D.
President,
State Board of Medical Examiners
1315 Blanding Street
Columbia, S. C. 29201

To The Editor:

It has been brought to my attention that some physicians appear to sometimes unnecessarily delay completing death certificates when autopsies are required. Although I realize this is at times unavoidable, there do seem to be situations whereby the lack of physician cooperation contributes to the delay.

In our discussion of this problem with the Department of Health and Environmental Control, it was decided that placing a time restriction on physicians would be counterproductive at present. We do request, however, that your Board make an effort to educate physicians as to this problem and as to the problems it causes families, funeral directors and creditors and to instruct them as to how to expedite the completion of death certificates.

This appears to be a sporadic problem that might be best addressed by thoughtful communication and cooperation rather than by regulation. Please give me the benefit of the Board's thinking on this after they have had time to consider my request.

Thank you for your cooperation and prompt attention to this matter.

Senator J. Verne Smith
P. O. Box 142
Columbia, S. C. 29202

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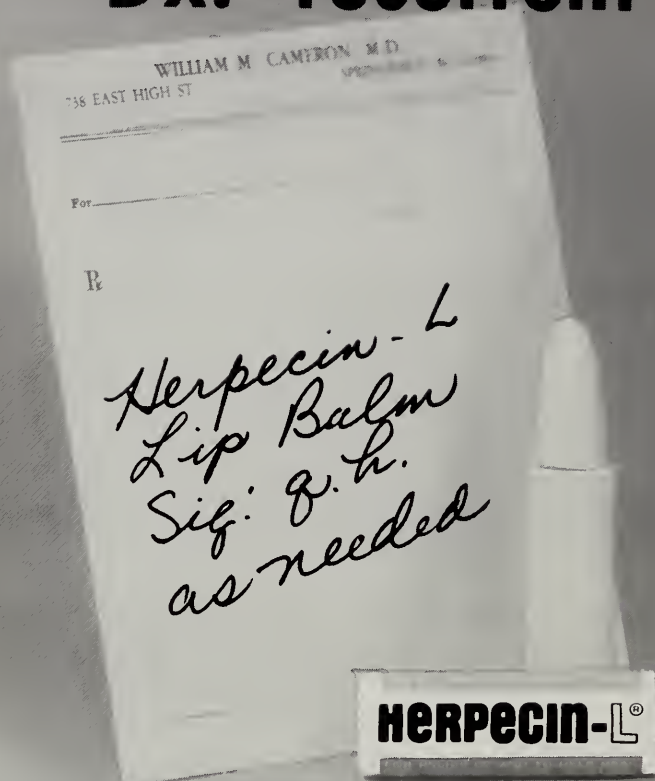
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PHYSICIAN RECOGNITION AWARDS

The following SCMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned.

Linwood G. Bradford, M.D.

Stacey Brennan, M.D.

George F. Cox, Jr., M.D.

George S. Croffead, M.D.

S. Perry Davis, M.D.

Arthur F. DiSalvo, M.D.

Richard L. Dobson, M.D.

Thomas M. Essman, M.D.

Arnold H. Franzblau, M.D.

James S. Garner, Jr., M.D.

James L. Green, M.D.

Robert F. Hagerty, M.D.

Lawrence A. Heavrin, M.D.

William H. Hester, M.D.

Robert L. Hillery, M.D.

Lewis E. Jones, M.D.

Donald G. Kilgore, Jr., M.D.

Henry A. Langston, M.D.

Robert G. Mann, M.D.

William P. Marshall, M.D.

Robert A. Martin, M.D.

George J. Neff, M.D.

Anthony J. Nicolette, M.D.

Lawrence H. Parrott, M.D.

Ernest A. Perry, M.D.

Michael E. Reed, M.D.

Howard D. Reines, M.D.

Henry W. Rittenberg, M.D.

Harold E. Shaw, M.D.

Ronald L. Skinner, Jr., M.D.

Hollis Snead, Jr., M.D.

Waitus O. Tanner, M.D.

Russell Tillitt, M.D.

James M. Timmons, M.D.

Richard P. Von Buedingen, M.D.

John L. Ward, M.D.

Michael C. Watson, M.D.

Charles S. West, M.D.

Thomas A. Whitaker, M.D.

Larry R. Winn, M.D.

FINANCIAL CHECKUP

MARTIN LEFKOWITZ
Certified Financial Planner
Tax Shelter Co-Ordinator: E.F. Hutton

Vol. 4, Issue No. 5

May 1985

THE TRUTH ABOUT TAX SHELTERS

Hold the eulogies--tax-sheltered investments are alive and well.

"The more things change," according to an old French proverb, "the more they remain the same." Take tax shelters for example. There is no question that as the country's economy and tax laws change, so do tax-advantaged investments. But one thing that has always remained the same is that any tax-advantaged program should be an economically sound investment first and a generator of tax benefits second. In the current environment, that goal looms larger than ever.

In brief, "the current environment" means the tax reform proposals suggested by the U.S. Treasury Department-- a set of recommendations that, if adopted as law, would either eliminate or materially weaken many of the investment incentives that have traditionally been part of the tax code. To take several important examples:

- * The depreciation schedule on real estate would be significantly lengthened-- to 63 years, as a matter of fact.

- * The depletion allowance on oil and gas investments would be cut back.

- * The Investment Tax Credit would be eliminated.

- * The "At Risk Rule" would be extended to real estate, meaning that real estate investors could no longer claim deductions of more than the amount they are actually liable for in any program.

- * The allowable deductions for investment expense would be significantly reduced.

- * The favorable tax treatment of capital gains would be eliminated.

- * And, in a move that would surely benefit only the very wealthy, all limited partnerships of more than 35 individuals would be taxed as corporations no later than 1990.

Not a pleasant scenario for the typical small investor--or, at first blush, for tax-sheltered investments. Now, if indeed every item of tax preference were simply to be axed--if Congress were to pass an across-the-board flat tax on all earnings irrespective of source--an investment whose primary benefit was in tax advantages would, in effect, be legislated out of existence. But for three different and important reasons, that is not the situation that investors are facing:

1. It is highly unlikely that Congress will adopt the radical, sweeping tax changes proposed by the Treasury Department. Diverse business, political and social interest groups, convinced that the Treasury proposals would do material harm to the national economy, are waging a spirited campaign to defeat the proposals.

(Financial Check-up cont'd)

And remember that the tax incentives built into the code were not placed there willy-nilly or for the exclusive benefit of wealthy individuals: They either encourage investment in industries key to national survival, like real estate and energy, or they channel money into certain socially advantageous investments, such as subsidized housing. Or both. It is not likely that Congress would deal a death blow in either of these directions.

2. For a variety of political reasons it will probably take Congress many months to decide exactly what tax legislation it does want to deliver. We are not facing an immediate tax crisis. In addition, Congress will almost certainly exempt any program organized prior to the time that the legislation is passed, "grandfathering" existing shelters. So, in a backhanded way, if the Treasury proposals do pass, this may be an ideal time to invest in shelters: the last point at which the current tax advantages apply in full force.

3. The last point suggests that even if the Treasury proposals become law, they would not devastate tax shelters. First of all, they do not in fact eliminate all tax advantages. For example, depreciation and depletion allowances will continue as tax benefits, even if their potency is reduced. This means that investors will still be able to shelter some of their income.

Second, in light of the fact that the Treasury proposals include cutting into many personal deductions and preferences as well, the attractiveness of the investment-related deductions that would remain intact might even loom larger. Third, the Treasury Department has proposed eliminating the deduction for state and local taxes. For investors in a high-tax state like New York, a 35% Federal tax bracket (assuming that this replaces the current 50% ceiling) translates into a total tax burden of about 47%.

Sheltering has hardly been eliminated as a desirable option.

Finally, the slowdown that the Treasury proposals would almost inevitably create in many industries would work to the advantage of investors--particularly current investors--in certain shelters. For example, if new real estate construction slows down, limited partnerships whose earnings depend on rental rates would profit significantly.

So, the tax shelter market is not dead. But that doesn't mean it's not changing. For a tax-advantaged investment to rise to the top in the new market, it must do more than just survive any likely tax code revision: it must make good sense as an investment. Specifically, investors will be noting some market trends that will almost certainly continue to strengthen into the foreseeable future.

(TO BE CONTINUED NEXT MONTH)

FURTHER INFORMATION

If you would like to receive further information on any of the topics covered in this newsletter, please write to Martin Lefkowitz, CFP, E.F. Hutton & Company, 2700 Middleburg Drive, Suite 200, Columbia, SC 29204; or Call (800) 922-1112.

* * * * *

The information contained herein has been obtained from sources believed reliable, but is not necessarily complete and cannot be guaranteed. Any opinions expressed are subject to change without notice. Neither the information presented nor any opinion expressed constitutes a representation by us or a solicitation of the purchase or sale of any securities. South Carolina Medical Association and E.F. Hutton & Company, Inc. 1985.

ON THE COVER:
CHARLES R. TABER, M.D.
1837-1898

In 1888, Charles R. Taber, M.D., assumed the Presidency of the South Carolina Medical Association. This was during a period when the society was beginning to recover from the scourges rendered upon South Carolina and its medical profession following the Confederate reconstructive period. In that year, there were 29 Delegates present at the Annual State Meeting; 14 counties were represented. In that year, the Association appointed Delegates to six other state associations. A young library was being formed by the society and 383 volumes were available. Times were changing and communication was becoming better organized. Physicians were spending more time in their development of organized state medicine wherein they could share experiences and political views.

Charles R. Taber, M.D., was born in Charleston. He graduated from the Medical College in that city and took post-graduate work at Bellevue Hospital in New York City. As a Confederate army medical officer, he was appointed as Assistant Surgeon and later rose to Assistant Surgeon General. He served throughout the south, but was largely employed within South Carolina. He spent time in Virginia on the Examining Board for Medical Officers in Richmond. He had a highly esteemed ability as a scholar, writer and speaker. In his Presidential Address to the Medical Association, his scholarly abilities were manifested by the learned dissertation that he presented to the members present. In the course of this text to that organization entitled, "Modern Materialism in Modern Medicine," Dr. Taber addressed the "holy of holies" in his attempt to define "what is life and where does it begin?" Showing great intellectual prowess, he intertwined the philoso-

phies of Plato, Socrates, Huxley, Malleschott and the poet, Goethe, in his attempt to establish his thesis regarding when life begins. In this modern world of 1985, when we see political forces and terroristic activities surrounding medical facilities for the care of women, one is awed by the foresight that Taber expressed in his 1889 dissertation. He stated that "life, therefore, as an expression of supreme activity and forecast, and as the complement of perfected law, must have preceded organization [i.e., the cellular biology/embryology of human development] and if life was before organization, it must have existed independently, and therefore can exist after organization." Goethe, he paraphrased, had described immortality of the soul as "setting, nevertheless the sun is always the same sun. I am fully convinced that our spirit is a being of nature quite indestructible, and that its activity continues from eternity to eternity."

Following the Confederate War, Dr. Taber returned to practice medicine near Fort Mott, South Carolina. In addition to becoming President of the SCMA, he was a member of the State Board of Health and later its Chairman. He was also a member of the State Board of Medical Examiners, and in 1887 Governor Tilman appointed Dr. Taber to represent South Carolina in forming an inspection team to determine the status of yellow fever in Cuba. Dr. Taber was a Delegate to the first Pan American Medical Congress in 1893 and to the International Medical Congress in 1888.

"A fine type of South Carolina's best manhood in the olden days," Dr. Charles R. Taber stood as a man of character, spirit, superb appearance and courtly manners.

— Thomas M. Leland, M.D., Ph.D.



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The American physician isn't extinct. But your freedom to practice *is* endangered. Increasing government intervention is threatening the quality of medicine – and your right to function as an independent professional. The government, responding to cost containment pressures from myriad sources, has taken a more active role in legislating reimbursement methods, payment levels and even access to care.

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SOUTH CAROLINA MEDICAL ASSOCIATION AUXILIARY



THE CHALLENGE OF CHANGE

Plato said, "Nothing endures but change." Over a thousand years later, the French Marquis de Racan observed, "Nothing in the world lasts save eternal change." However, the changes confronting physicians' families today are the most drastic and dramatic in the history of our country. Periodicals confirm this assertion. The October 15, 1984 *Business Week* cover was emblazoned "Corporate Rx for Medical Costs — Changing How the Health Care Industry Works," and the March, 1985 edition of the *South Carolina Business Journal* headlined "State Chamber Working for Pro Business Health Care Legislation." Federal, state and local governments, insurance companies, large corporations, and small businesses are all impacting on the methods of health care delivery. Regulations and legislation are dictating changes in the practice of medicine. Dr. Leonard Douglas has stated that his practice has changed more in the last year than in the preceding twenty-five years.

What is the role of the Auxiliary? Our challenge is to accept this challenge of change, not in a stance of confrontation but with a desire to devise creative approaches that will enhance the practice of medicine. There are many keys we as auxiliaries can use. Considering that the number of physicians in our state has more than doubled in the last ten years, that competition is threatening to replace the colleague to colleague mindset, and that alternative health care delivery systems are a reality in South Carolina, the Auxiliary can recommit to our pledge "... to promote friendly relations among physicians and their families." Cooperating and coordinating with the South Carolina Medical Association will strengthen our ability to cope with the challenge of change. Promoting contact with the media will be beneficial to the public's image of physicians and their families. Our work in Health Projects and AMA-ERF fund-raising is outstanding, and we need to communicate that to the citizens of our state. In legislation, it is essential that we increase our involvement with SCAPELL and be capable of keeping our legislators informed on the issues concerning the practice of medicine. We must have a strong membership, dedicated to the ideals and moral and ethical codes of the profession. We must care for our members so that they can provide support for their spouses.

We may feel beleaguered today. However, in 400 B.C., Hippocrates wrote, "Medicine is the most distinguished of all the arts, but, through the ignorance of those who practice it, and of those who casually judge such practitioners, it is now of all the arts by far the least esteemed." Let us join together to meet this challenge of change and to assure that Hippocrates' assessment in 400 B.C. will *not* be the reality of 2000 A.D.

MRS. WARREN Y. (SKIPPY) ADKINS
President, SCMA Auxiliary

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MEETING ANNOUNCEMENT

S. C. Chapter, American Academy of Pediatrics, Annual Scientific Session "Pediatrics for the Practitioner". Faculty: Vincent A. Fulginiti, M.D., Martin H. Smith, M.D. and Martha Duke Yow, M.D. Meeting Site: Marriott's Hilton Head Resort, Hilton Head Island, South Carolina. Meeting Dates: Thursday, August 8 - Sunday, August 11, 1985. Credit: AMA Category I and PREP, 7 hours. For more information contact: B. J. Blanks, S. C. Chapter AAP, P. O. Box 11188, Columbia, S. C. 29211, (803) 798-6207.

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President's Page



SCMA — A LONG HISTORY OF SERVICE

What has the South Carolina Medical Association done for me or my patients lately? It behooves us all to ask that question occasionally. When we count the contributions of the SCMA we can better appreciate organized medicine in South Carolina.

For a moment, let's imagine the physicians and the public of South Carolina without the SCMA. What would your practice be like? What benefits and services would be lacking for your patients? Do you think your specialty society is large enough or strong enough to cope with the many problems and concerns we face? I doubt it!

What organization or group could have responded as quickly or decisively to the crisis, in late April, concerning the Board of Medical Examiners? None! Who would monitor legislation, have bills introduced, and lobby the legislature on a daily basis to protect the interest of medicine and the patients we serve? No one!

And the list goes on and on. When I think of the many long hours and years of the dedicated service of my colleagues — past and present — in the South Carolina Medical Association, I am extremely proud. I'm proud of our accomplishments and ongoing progress, not to mention the exciting and effective work of our Auxiliary. And these efforts will go forward with or without one hundred percent support of South Carolina physicians.

I must admit my distress (and sometimes anger) when I hear some reasons for non-membership in the SCMA. Some seem to be narrow in scope — such as some “pet project” of a physician not being totally accepted or resolved.

The same problems exist on the national level. Can you believe that less than 50 percent of physicians in America belong to the American Medical Association? Unbelievable! Who else can represent us?

These are exciting times for medicine — and the challenges are many. I am confident we are equal to the task.

I plan to use the “President's Pages” this year to speak out on issues that concern your SCMA leadership. We belong to the finest profession in the world — and we deserve the finest representation — for the patients we serve and the public with whom we deal. I welcome your thoughts and comments. Please feel free to contact me. Many already have, and I am grateful.

The “bottom line” is — you cannot afford *not* to belong to the South Carolina Medical Association!

Sincerely,

A handwritten signature in cursive script that reads "Leonard".

LEONARD W. DOUGLAS, M.D., *President*



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LOWER EXTREMITY SALVAGE WITH MICROVASCULAR FREE FLAPS*

EDWARD L. HAY, M.D.**

GERALD J. SHEALY, M.D.

DOUGLAS P. HANEL, M.D.

LELAND C. STODDARD, M.D.

Reconstruction of the massively traumatized limb presents a formidable challenge. Without adequate soft tissue coverage, bony opposition, vascular reconstitution, and nerve repair are futile, frustrating endeavors for both the patient and the reconstructive surgeon. Recent development in microsurgical technique and a renewed appreciation of small vessel anatomy now allow us to salvage many limbs which previously would have been amputated. This paper discusses the use of free, composite tissue transfer and presents examples of its clinical application.

DEFINITION

A microsurgical free flap is a composite graft supplied by a definable vascular network which consists of one or more of the following tissues: skin, fascia, fat, muscle, nerve or bone. The donor is transferred over such great distances that the blood supply must be severed at the donor site and reconstituted by microsurgical techniques at the recipient site.¹

HISTORY

Free tissue transfer was made possible through the introduction of the surgical microscope in the 1940's, the modification of large vessel surgical

techniques for use under the microscope in the 1950's, the development of appropriate instrumentation in the 1960's and the bold application of these advances in the 1970's. The first successful free composite tissue graft was performed by Harii in 1972. In the ensuing twelve years since this remarkable event, over 30 donor sites have been developed.²

The state of this technique is such that a particular donor site can be picked to deal with the specific needs of a recipient site. The patient can also be assured that when performed by an experienced surgical team, the procedure will be successful in 80 to 90 percent of cases. Considering that the alternative treatment in many cases of extremity reconstruction is amputation, this success rate is most gratifying.

ADVANTAGES

When compared to conventional coverage procedures, free tissue transfer has the following advantages:

- A. It is a single stage procedure requiring one hospitalization. Most conventional procedures require multiple stages and multiple hospitalizations.
- B. The tissue can be transferred to distant sites without regard for position or placement. In contradistinction, conventional grafts frequently require prolonged periods of conformed and non-physiologic posturing. (Witness the patient whose ankles are tied

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together for four weeks as he awaits the "maturation" of a cross leg lap.)³

- C. Free tissue transfer brings a well-vascularized tissue to the wound it is covering. This enhances healing and prevents infection. Conventional grafts are parasites requiring the transferred tissue to gain blood supply from the tissues bordering the defect it is covering.
- D. Free tissue transfer provides tremendous versatility for the reconstructive surgeon.
 1. Enervated skin can provide sensation where it is absolutely essential such as the heel. (Donor examples — lateral arm skin, dorsal foot skin, lateral aspect of great toe.)^{4, 5, 6}
 2. Enervated muscle can return active motion to a limb whose muscles have been avulsed or crushed but whose nerve supply remains intact. (Donor examples — gracilis, pectoralis major, latissimus dorsi.)⁷
 3. Vascularized bone can effectively bridge large bony gaps secondary to trauma or congenital pseudo-arthroses. (Donor examples — iliac crest, fibula, lateral border of scapula, split radius, rib.)^{8, 9}
 4. Vascularized fascia has recently been used in areas where thin grafts are desirable such as the dorsum of the hand. (Donor examples — lateral arm fascia,¹⁰ temporalis fascia.)
 5. Muscle flaps have become the treatment of choice for large cavitory defects of the extremity. (Donor examples — latissimus dorsi, tensor fascia lata, gracilis, serratus anterior.)^{11, 12, 13, 14}
 6. Free skin grafts are used to cover large noncavitory soft tissue defects. (Donor examples — scapula, lateral arm, radial forearm.)^{15, 4, 16}

ANATOMY AND TECHNIQUE

The anatomic basis for free tissue transfer is a detailed knowledge of the dominant blood supply to a particular donor region. This is referred to as the territory of a given vascular system. It is particularly applicable to free skin grafts which are centered about a dominant "axial" pedicle (artery and venae comitantes). In the case of myocutaneous flaps the skin territory is supplied by muscular perforating branches which arose from

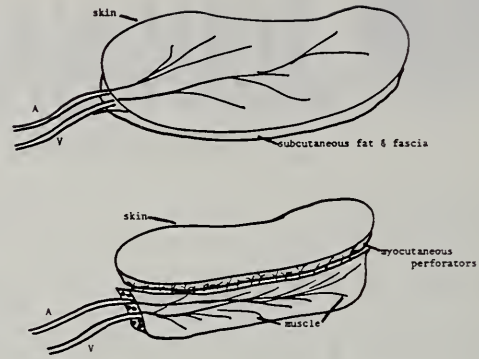


FIGURE 1. Blood supply to skin by "axial" pedicle (top) or through muscular perforating branches (bottom).

the nutrient artery of the muscle over which the skin lies (Fig. 1). Many of these territories were defined by Manchot in the 19th century, but it wasn't until the development of microvascular technique that they could be used to clinical advantage.¹⁷

The technique of free tissue transfer begins with developing a clean recipient site void of contamination and infection. The defect is assessed and a particular donor site selected to fulfill the need of the recipient bed. The donor tissue is elevated within the limits of its vascular territory. Care is taken to identify, isolate, and then divide the dominant artery and vein. The donor tissue is transferred to the recipient bed, sutured in place and revascularized using vessels previously identified within the recipient bed. The success of the transfer is assessed by the presence of capillary refill, bleeding from the graft edges, skin temperature, skin turgor, and in the long run the behavior of the wound.

CLINICAL EXAMPLES

Case No. 1. A 27-year-old female involved in a motor vehicle accident sustained multiple, severely contaminated, bilateral open fractures of both lower extremities. Vascular compromise and infection resulted in amputation of the right leg below the knee. Multiple reconstructive procedures salvaged the other lower extremity but left it with an insensate, chronically abraded skin graft over the calcaneus (Fig. 2a). This problem was dealt with by excising the unstable grafted area and transferring skin, subcutaneous fat, and fascia from the lateral aspect of the arm. (The

LOWER EXTREMITY SALVAGE

“lateral arm flap” is a piece of tissue which is supplied by a terminal branch of the profunda brachii artery and enervated by the posterior cutaneous nerve of the arm.) On transfer to the leg, the donor was re-enervated with a branch of the sural nerve and revascularized by anastomosis to the tibialis posterior artery in its venae comitans. Although re-enervation is not yet complete, the patient has done well, ambulating in shoes without recurrence of breakdown or ulceration (Fig. 2b).

Case No. 2. A three-year-old boy was run over by a riding lawn mower, suffering an amputation of the os tubercle of the calcaneus and avulsion of the skin over the posterior aspect of the distal leg. Initial management salvaged the foot but left the dorsal leg covered with chronic granulation tissue and the calcaneus exposed, necrotic and infected (Fig. 3a). Upon transfer to our care the wound was thoroughly debrided, the proximal leg skin grafted and the heel defect covered with a latissimus dorsi myocutaneous composite graft (Fig. 3b). The child has returned to unlimited ambula-

tion. (The latissimus dorsi free graft is the “work-horse” of lower extremity reconstruction. Its vascular pedicle, a branch of the subscapular artery, is reliable and easily dissected. Although in this case a latissimus dorsi was harvested as a myocutaneous flap, that is, the muscle and overlying skin, it is more often harvested as a muscle only flap. The muscle is then covered with a split thickness skin graft. Doing the latter leaves a minimal donor defect, allows greater versatility in positioning the graft and makes for less bulky donor tissue.)

Case No. 3. A 46-year-old male sustained a comminuted open tibia-fibula fracture which resulted in a 8cm. bony deficit and a 10 x 15cm. soft tissue defect (Fig. 4a and b). The limb was stabilized with external fixation, the wound adequately debrided and a composite graft of soft tissue and bone used to reconstruct the leg. In this case, the composite came from the groin. Skin and iliac crest supplied by the deep circumflex iliac artery and vein were harvested as a unit (Fig. 5) and transferred to the leg. Revascularization of



FIGURE 2a. Pre-operative photograph demonstrating friable split thickness skin with chronic ulceration of the heel.



FIGURE 2b. Post-operative photograph with lateral arm flap providing padded, durable skin with protective sensation.



FIGURE 3a. Three months status post lawnmower injury with chronic granulation tissue covering the posterior portion of the distal leg and ankle with exposed and necrotic and infected calcaneus.



FIGURE 3b. Eight weeks status post debridement and application of lattissimus dorsi myocutaneous flap to the heel defect.

the composite tissue was with anastomosis to the posterior tibial vessels of the leg. At eight weeks postoperatively, the patient demonstrates excellent soft tissue coverage and bony consolidation of the osseous graft (Fig. 6a and Fig. 6b).

SUMMARY

Free tissue transfer, although a relatively new procedure, has become the treatment of choice for reconstruction of massive soft tissue and bony defects. It is a demanding endeavor that requires newly developed skills, delicate instrumentation, and an appreciation for detailed anatomy. With the application of this technique many limbs which previously would have been amputated can, in a most expeditious fashion, be salvaged. □

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FIGURE 4a. Comminuted open tibia with 8cm. bony defect and 10 x 15cm. soft tissue defect.

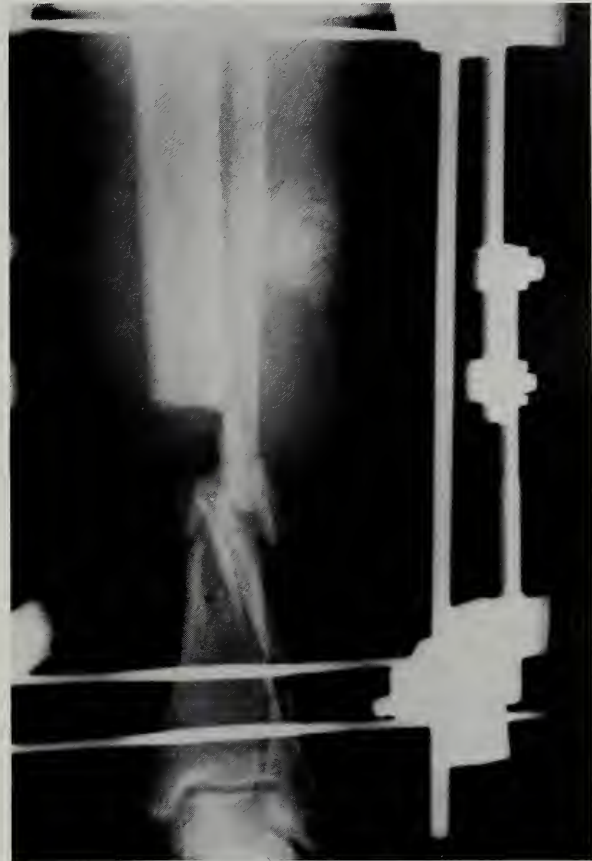


FIGURE 4b. AP radiograph demonstrating bony defect.

LOWER EXTREMITY SALVAGE

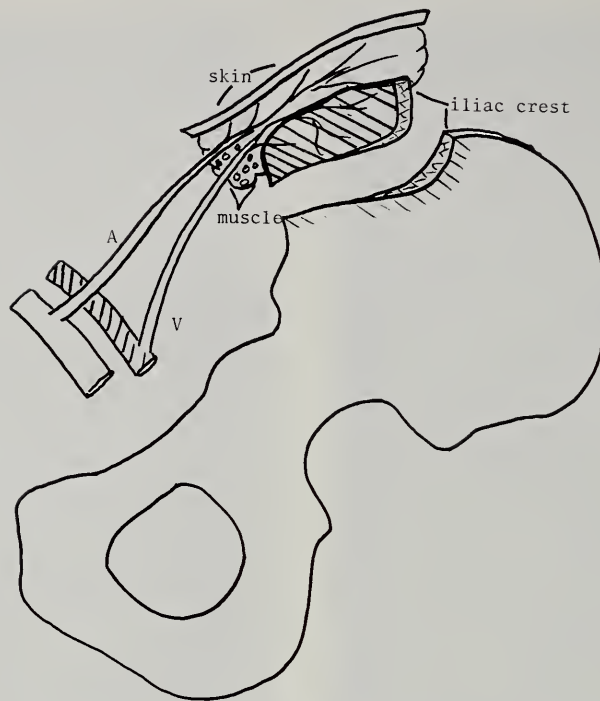


FIGURE 5. Free osteocutaneous graft from groin (based on deep circumflex iliac artery and vein).



FIGURE 6a. AP and lateral radiograph demonstrating bony consolidation of iliac crest graft.



FIGURE 6b. Healed soft tissue defect photographed at four weeks postoperatively.

DIABETES AND PREGNANCY IN SOUTH CAROLINA*

FRANCES C. WHEELER, Ph.D.

JAMES E. FERGUSON

CATHERINE C. MURPHY, M.P.H.

While several major medical centers report excellent results in managing pregnancies for women with diabetes,¹⁻⁴ epidemiologic studies of diabetes in pregnancy suggest that excess diabetic perinatal mortality remains a serious problem in the general population.⁵ In South Carolina, for example, diabetic perinatal mortality in 1978 was shown to be more than four times higher than that experienced by non-diabetic women.⁶

Since that time, a variety of local and national initiatives have promoted the utilization of prevention measures — such as specialty care, hospitalization and intervention prior to term, fetal monitoring, maternal glycemic control and neonatal care — for reducing diabetic perinatal mortality. Widespread adoption and application of these principles of care would be expected to result in significant improvements in pregnancy outcome for women with diabetes. The purpose of this paper is to provide an updated report on the status of diabetic perinatal mortality in South Carolina: (1) to estimate the prevalence of diagnosed diabetes in pregnancy, (2) to describe diabetes-related perinatal mortality in the state, and (3) to examine selected care-related variables thought to influence diabetic pregnancy outcome.

METHODS

Methods for identification of diabetic deliveries from hospital discharge data and vital records have been described in detail elsewhere,⁶ and will be briefly summarized here. Case identification included all live birth certificates with diabetes listed as a complication of pregnancy, all fetal death reports with maternal diabetes listed as a contributory cause of death, and all hospital discharges listing diagnostic codes for both an obstetrical delivery and maternal diabetes. Deliveries identified through hospital discharge data were

matched with those identified from vital records to eliminate duplication and to ensure that no events were omitted. Hospital records of the diabetic mothers, as well as the charts of the infants, were reviewed for purposes of data collection. The case definition for maternal diabetes was: disease recognized and coded as a hospital discharge diagnosis or as a diagnosis on a birth certificate or fetal death report. Perinatal mortality was defined as the number of fetal deaths (≥ 20 week gestation) plus the number of neonatal deaths (≤ 27 days) per 1000 deliveries (live births plus fetal deaths).⁷ Abortions and multiple births were excluded from consideration.

RESULTS

Case Identification:

Among 45,658 deliveries (live births and fetal deaths) recorded in South Carolina in 1980, there were 405 events in which maternal diabetes was listed as a complication of pregnancy or cause of fetal death. Eighty-seven percent of the recognized diabetic deliveries could be identified through the hospital discharge data system, as compared to 52 percent reported by the vital records data system.

Prevalence of Diabetes in Pregnancy:

The prevalence of diabetes in pregnancy was determined by comparing diabetic deliveries with deliveries in the total population. As shown in Table I, the diabetic natality rate was 8.9 diabetic deliveries per 1000 total deliveries; thus, about one in 110 pregnancies involved diabetes. The diabetic natality rates for whites and non-whites were, respectively, 7.6/1000 and 10.5/1000, a significant difference ($p < 0.001$).

Approximately two-thirds (66 percent) of the diabetic deliveries were identified as a maternal diagnosis of overt diabetes, i.e., disease known prior to pregnancy. Another 31 percent were coded as gestational diabetes, or abnormal glucose

* From the South Carolina Department of Health and Environmental Control, 2600 Bull Street, Columbia, S. C. 29201 (address correspondence to Dr. Wheeler).

DIABETES AND PREGNANCY

Table I
PREVALENCE OF DIABETES IN PREGNANCY BY
RACE IN SOUTH CAROLINA IN 1980

	White	Non-White	Totals
Diabetic Deliveries	200	205	405
Total Deliveries	26,078	19,580	45,658
Diabetic Natality Rate* . . .	7.7	10.5	8.9

*Diabetic deliveries per 1000 total deliveries.

Table II
DIABETIC PERINATAL MORTALITY
BY RACE IN SOUTH CAROLINA IN 1980

	White	Non-White	Totals
Total Diabetic Deliveries . .	200	205	405
Live Births	184	190	374
Neonatal Deaths	5	2	7
Fetal Deaths	11	13	24
Perinatal Mortality Rate* .	80.0	73.2	76.5

*Perinatal deaths per 1000 deliveries.

tolerance in pregnancy, while three percent could not be definitively classified.

Diabetic Perinatal Mortality:

As shown in Table II, the 405 identified diabetic deliveries included 31 perinatal deaths, with an overall diabetic perinatal mortality rate of 77 deaths per 1000 deliveries. This is 3.5 times higher than the non-diabetic perinatal mortality rate of 22 deaths per 1000 deliveries.⁸ There were no significant differences in diabetic perinatal mortality between whites and non-whites.

Table III shows the observed numbers of births and deaths, as well as perinatal mortality rates by type of diabetes therapy. For the total study population, 43 percent of deliveries occurred among women treated with insulin, while 65 percent of the total perinatal deaths occurred among this group. The perinatal mortality rate for women on insulin therapy is significantly ($p < 0.01$) higher than the mortality rate for women on diet therapy or with no listed therapy; however, perinatal mortality for women on oral hypoglycemic medication is by far the highest among all modes of therapy.

Perinatal mortality also varied greatly with the

classification of maternal diabetes. A perinatal mortality rate of 112 per 1000 was observed among women diagnosed as having overt diabetes, as compared to a rate of only eight per 1000 among those diagnosed as having gestational diabetes.

Care-related Variables:

Four care-related variables, which have been suggested as preventive measures associated with improved pregnancy outcomes, were examined in relation to observed perinatal mortality. As shown in Table IV, use of these measures varied greatly, as did the mortality associated with each variable. Only maternal glycemic control (as estimated by blood glucose level on admission) and delivery by Caesarian section were shown to have a significant ($p < 0.05$) positive correlation with improvements in perinatal mortality. The higher diabetic perinatal mortality observed with deliveries in Level III hospitals was not found to be statistically significant ($p = 0.24$).

DISCUSSION

Prevalence of Diabetes in Pregnancy:

In this retrospective study, case identification was limited to maternal diabetes recognized and recorded in the hospital chart or on the birth certificate or fetal death report. O'Sullivan *et al.*⁹ have suggested that approximately one pregnancy in 80 (12.5 per 1000 deliveries) is associated with diabetes that can be detected after screening, but in this study about one in 110 pregnancies (8.9 per 1000 deliveries) was identified as diabetic. Thus, nearly one-third of all diabetic pregnancies may not have been recognized.

The combined use of vital records and hospital discharge data is thought to provide a fairly accurate picture of diagnosed diabetes in pregnancy. Underreporting of diabetes as a complication of pregnancy could lead to underestimation of diabetes in pregnancy (particularly if only vital records are used as a data source), although it seems likely that under-diagnosis of gestational diabetes is a more significant problem. The incidence of gestational diabetes is much greater than that of overt diabetes,⁹ but in this study only 31 percent of the total cases were identified as gestational diabetes. This suggests that the need for systematic detection of diabetes in pregnancy is an issue that warrants further consideration.

DIABETES AND PREGNANCY

Table III
DIABETIC PERINATAL MORTALITY BY THERAPY IN
SOUTH CAROLINA IN 1980

	<i>Insulin Therapy</i>	<i>Oral Meds</i>	<i>Diet Only</i>	<i>None or Unknown</i>	<i>Totals</i>
Total Diabetic Deliveries	174	6	160	65	405
Live Births	154	2	153	65	374
Neonatal Deaths	7	0	0	0	7
Fetal Deaths	13	4	7	0	24
Perinatal Mortality Rate*	114.9	666.7	43.8	0	76.5

*Perinatal deaths per 1000 deliveries.

Table IV
USE OF SELECTED PREVENTIVE MEASURES AND ASSOCIATED DIABETIC
PERINATAL MORTALITY IN SOUTH CAROLINA IN 1978

<i>Variable</i>	<i>Observed Frequency (%)</i>	<i>Perinatal Mortality^a</i>
Maternal Glycemic Control ^b	41.5	35.7
Prior Hospitalization ^c	41.2	73.5
Intervention Prior to Term ^d	37.0	53.3
Delivery at Level III Hospital	35.8	89.7

^a Perinatal deaths per 1000 deliveries

^b Maternal blood glucose 60-120 mg% on admission

^c More than one hospitalization prior to delivery

^d Delivery by Caesarian section

Perinatal Mortality:

This study documents a very high rate of diabetes-related perinatal mortality in South Carolina. Perinatal mortality among diabetic women (77 deaths/1000 deliveries) is 3.5 times higher than for non-diabetic women (22 deaths/1000 deliveries). The fact that most (77 percent) perinatal losses were due to fetal rather than neonatal deaths suggests problems in detecting intrauterine fetal jeopardy in time for successful intervention.

Care-related Variables:

A retrospective review of hospital charts and vital records does not allow thorough investigation of events and actions that may have occurred before the hospitalization for delivery, but it is possible to examine selected care-related variables that are, in general, well-documented in the hospital record. Of the four variables included in this study, none were frequently observed and only two (maternal glycemic control and intervention prior to term) were clearly associated with reductions in perinatal mortality.

Hospitalization prior to admission for delivery and delivery at a Level III hospital were not correlated with improved outcomes. However, this observation may be somewhat misleading without consideration of other factors such as severity of disease or presence of concurrent com-

plicating conditions. Pre-delivery hospitalization and/or transfer to another facility may have been used only in those cases which were most severe or difficult to manage.

Reports from specialized centers indicate that risk-reducing measures, such as those examined in this study, can contribute to decreases in diabetic perinatal mortality. However, this study showed infrequent utilization of the care-related variables that were examined and inconsistent results with regard to reductions in perinatal mortality. A more thorough assessment of causes is needed to delineate the factors contributing to the excessive diabetic perinatal mortality in South Carolina.

SUMMARY

In spite of the limitations imposed by retrospective record review, this study illustrates the usefulness of vital records and hospital discharge data as a means of examining diabetic pregnancy outcomes. The data obtained indicate that many diabetic pregnancies in South Carolina may be unidentified because of under-reporting and/or under-diagnosis of maternal diabetes.

Diabetic perinatal mortality was found to be 3.5 times higher than for nondiabetic pregnancies, with most perinatal losses resulting from fetal rather than neonatal deaths. Recommended ap-

DIABETES AND PREGNANCY

proaches to management and care seem to be underutilized and were not uniformly associated with improved outcomes.

ACKNOWLEDGMENTS

The authors wish to acknowledge the valuable assistance provided by the South Carolina Office of Cooperative Health Statistics, the South Carolina Hospital Association and its member institutions, the South Carolina Medical Association, and the South Carolina Medical Records Association. We particularly want to thank Catherine Sullivan, Debra Faust, Lynn Owens, Fernanda Nelums, Dr. Kay McFarland and Dr. Malcolm Dantzler for their assistance in completing this work. This study was supported in part by Cooperative Agreement Number U32/CCU400437-01 from the Centers for Disease Control. □

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GCMIA

NEWSLETTER

June, 1985

ELECTIONS: STATE BOARD OF MEDICAL EXAMINERS

By the time this Newsletter reaches your office, you should also have received letters from the State Board of Medical Examiners outlining the election procedures for members of the Board and Disciplinary Commission. Included in the mailing is a copy of the new law and a copy of the Emergency Regulations.

The elections are being held by the Interim Board under the emergency regulations mentioned above which were filed on May 22 by the Attorney General's office.

Physicians offering their candidacy for Board positions must submit a written petition provided by the Board and signed by not less than 50 physicians in the Congressional District for the particular Board position. Physicians eligible to vote in that election may sign a petition for more than one candidate. If only one candidate is nominated, he or she shall be declared elected. If more than one candidate submits the required number of petition signatures, ballots will be prepared and mailed by the Board, and the candidate receiving a majority will be declared elected. Ballots must be returned within 15 days.

The same procedure will be followed for the At Large position on the Board except that signatures may be from physicians in the state-at-large.

With regard to election of the 18 members of the Disciplinary Commission, basically the same procedures will be followed as in the election of Board members from each Congressional District, except that the number of physician signatures required on each petition is no less than 25. Three members of the Commission will be elected from each of the six Congressional Districts, however, and if more than three candidates submit the required petition signatures, again ballots will be prepared by the Board and mailed to every physician qualified to vote in that District. Each voter may vote for three candidates and the three receiving the most votes will be declared the winners.

Physicians are reminded that nominations will close on July 12, 1985, and petitions for nomination received after that date will not be considered by the Board.

RESOLUTION F-7 - HEALTH INSURANCE REGULATION -

was adopted by the SCMA House of Delegates in April. It calls for a committee to research and encourage investigation into health insurance regulation in this state, specifically to compare the expense of comparable policies in neighboring states. Ultimately, this committee would "make recommendations to the Legislature and the Governor concerning how the health insurance industry might be better regulated in order to avoid generation of such huge profits at the expense of the people of South Carolina."

Charles R. Duncan, Jr., M. D., has agreed to serve as Chairman of this Ad Hoc Committee, at the request of SCMA President *Leonard W. Douglas, M. D.* The appointment of other committee members is under consideration at this time.

IT'S A RECORD YEAR IN SCMA MEMBERSHIP.

For the eighth consecutive year, the SCMA has established a new membership record! It was anticipated that a record would be set, but to accomplish the feat in May makes it much more gratifying.

At the 1985 Annual Meeting in Charleston, 89 Delegates and Alternate Delegates agreed to help in the membership recruiting effort by joining the "You Can Count On Me" campaign. For the most part, there has been real activity by those who agreed to participate, and it has made a difference!

The greatest increase has been the full dues-paying (active member) category. Student membership has increased but there has been a slight decline in House Staff members.

One year ago, the Board of Trustees (formerly Council) established a goal of 2,500 active members in 1985. At this time, we are only 125 members from that goal and it appears, with appropriate follow-up by the membership, we will attain it. The Board of Trustees wishes to thank all members who have helped in the 1985 membership campaign. Because of your efforts, our overall programs have a greater potential for success.

AUDIO TAPES OF SPECIAL MEETINGS...

will be available for use by county societies and individual members. The SCMA Executive Committee has authorized staff to arrange for audio tapes of meetings such as the SCMA Leadership Conference. The SCMA Risk Management Seminar at the 1985 Annual Meeting is now available on videotape. Contact the SCMA Office of Information for details.

MARK YOUR CALENDARS NOW...

for the 1986 SCMA Annual Meeting. It will again be held at the Sheraton Charleston Hotel, April 23 through April 27, 1986.

JUDGE SARAH EVANS BARKER HAS DISMISSED....

the AMA lawsuit filed in federal court to seek answers to the constitutional questions raised by the Medicare amendments to the 1984 Deficit Reduction Act. Judge Barker ruled the regulations do not violate the right of Medicare patients to choose any physician they want. She also rejected arguments that the Medicare rules violate constitutional guarantees of equal protection by limiting the amount physicians may charge to Medicare beneficiaries.

THE PEOPLE'S MEDICAL SOCIETY....

has blanketed the nation with a series of membership-solicitation letters attacking the AMA and physicians in general and promoting approaches "designed to help people take responsibility for their own health." These letters have been characterized by outlandish allegations and specious arguments.

SCMA Headquarters has had numerous calls from physicians who not only have received the letter but whose patients have commented about it. For that reason, the following information, furnished by the AMA, is presented. Members are urged to become familiar with the corrections to inaccurate and misrepresented statements about the AMA and organized medicine.

People's Medical Society claims that the AMA seeks only to protect the financial health of its members, thereby affecting patients' costs, Medicare benefits and the quality of their care. On the contrary, the AMA realizes that high quality care cannot be provided at "bargain basement" prices. Also, the AMA recognizes that America's patients don't want and won't accept the bargain basement care which would result if costs were to become the primary consideration.

The society charges incorrectly that the AMA fought against establishing any "Medicare" system 20 years ago. The truth is that the AMA supported a program for health care of the low income aged who could not afford insurance premiums or cost of care. In regard to the voluntary freeze of physicians' fees requested by the AMA in early 1984, the PMS scoffs at its effectiveness. Yet a reliable, independent, outside research firm surveyed physicians and found that nearly 80 percent were complying with the request -- and this was effective for all their patients, not just Medicare.

The PMS says the AMA has failed to voluntarily reduce spiraling medical costs. This is a naive assumption that fails to recognize the multiple and complex factors that have caused health care costs to rise. And, according to government statistics for several recent years, physicians receive only 19 cents of each health care dollar.

The PMS writes disparagingly of AMA's efforts to find equitable solutions to the professional liability insurance crisis. It should realize that those efforts are intended to ensure that patients who do suffer from medical errors will be appropriately compensated, but to also eliminate unreasonable and unrelated costs. In the end, everyone will benefit from such a system.

South Carolina physicians can assure their patients that modern American medical care, the best in the world, is really worth the costs. Urge those who receive the PMS letter to consider whether they want Washington officials and bureaucrats to dictate changes in medical care that will lower that quality and decrease the availability of care. Such actions -- the real threat to the nation's health -- are the ones the AMA and the SCMA oppose.

PHYSICIANS VIEW MEDICAID DIFFERENTLY;

their attitudes range from 'wouldn't touch it with a ten foot pole' to extensive support and participation. Statistics show that 3,061 physicians in South Carolina are enrolled in Medicaid. This represents about 3/4 of the private practicing physicians in the state.

Why is it that some Medicaid clients cannot find a family physician? In a 1983 survey conducted by the SCMA, physicians cited the following major problems: *low reimbursement; excessive paper work, and lack of cooperation by Medicaid staff.*

What has been done to correct these problems? The Medicaid and Indigent Care Committee of the SCMA and the Medicaid staff have been working together to resolve these and other problems. Since that time, reimbursement for office visits has been increased 28 percent (from \$9.36 to \$12.01 for 90050), the number of items to be completed on a claim has been reduced to 14 (there are 34 items on a claim form), and staff has redoubled their efforts to be cooperative. Additionally, Medicaid has incorporated the following suggestions from physicians into the program: cover pneumovax; allow additional reimbursement for after hours, holiday and Sunday office services; eliminate the need for reports on extensive consultations and allergy injections.

Physicians are the backbone of the Medicaid program. The Health and Human Services Finance Commission needs their support and participation to be successful, and expects to earn it through hard work and cooperation. *For more information on Medicaid or to communicate suggestions, please call or write Ken Kamis, Director of Primary Care, at 803/758-3939, State Health and Human Services Finance Commission, P. O. Box 8206, Columbia, SC 29202.*

THE MEDICAL ASPECTS OF SPORTS COMMITTEE...

of the North Carolina Medical Society extends a cordial invitation to South Carolina physicians to attend its 1985 Sports Medicine Symposium. This year will be the 15th Annual conference. It is scheduled for Friday, July 5 through Sunday, July 7 at the Blockade Runner Hotel in Wrightsville Beach, North Carolina.

Those interested in attending should contact Mr. Alan Skipper at the North Carolina Medical Society, P. O. Box 27167, Raleigh 27611, 919/833-3836.

CAPSULES....

J. Gavin Appleby, M. D., SCMA President-Elect, was recently appointed to the Commission on Legislation and Governmental Affairs of the American Academy of Family Physicians. The commission has a variety of functions, including investigating qualifications of candidates for public office and recommending to the Board of Directors any policies or actions that the academy may formulate or perform for general improvement in medical care.

William L. Perry, M. D., a former President of the SCMA and former Alternate Delegate to the American Medical Association, has been elected to the 1985 Board of Visitors of the Medical University of South Carolina.

The following physicians have been awarded honorary membership status in the SCMA: *Robert A. Brown, Jr., M. D., Wallis D. Cone, M. D., and Cortland D. Leigh, M. D.*

EXPERIENCE WITH FLEXIBLE SIGMOIDOSCOPY IN A TRAINING PROGRAM*

CLIVE D. BROCK, M.B., Ch.B.
BARRY L. HAINER, M.D.

In July, 1983, a training program to teach residents the technique of flexible fiberoptic sigmoidoscopy was begun in the Department of Family Medicine, Medical University of South Carolina. This paper describes the implementation of this procedure, our problems and successes, to encourage others to initiate similar training programs.

GOALS OF TRAINING PROGRAM IN FLEXIBLE SIGMOIDOSCOPY

Prior to July, 1983, faculty and residents rarely performed sigmoidoscopy, only about 10 examinations per year in a total patient population of 12,000 (with 2,044 patients being over the age of 50). A rigid instrument was utilized for these examinations. After discussion with local gastroenterologists, a literature review, and appraisal of available equipment, we acquired a 35 cm. flexible fiberoptic sigmoidoscope (FFS)** to perform this examination in the Family Medicine Center.

Members of the Division of Gastroenterology, Medical University of South Carolina, encouraged faculty members and residents of this Department to become skillful in this procedure. Their promised cooperation to assist with training and to provide backup assistance and consultation was a significant factor in the decision to incorporate this procedure in this program.

The literature review showed the superiority of the FFS over the rigid sigmoidoscope in terms of colo-rectal disease detection and patient comfort.¹ In addition to greater safety and comfort, one study demonstrated that physician willingness to undertake the procedure and patient acceptance

of sigmoidoscopy increased from zero to twenty-one percent in an "at risk" group of patients.²

Our goal was to introduce this as a screening procedure for patients over 50 years old and those at high risk for colo-rectal cancer and so to emphasize preventive health care. To accomplish this goal, two faculty members became skilled in the use of the flexible sigmoidoscope in order to teach residents this procedure.

INITIAL PRECEPTOR PREPARATION

Two physicians, already experienced in the use of the rigid sigmoidoscope, enrolled in an intensive three-day course to begin learning to use the FFS. In addition to didactic lectures and demonstrations, there was hands-on experience utilizing recto-sigmoid models. Following this, patient examinations were performed by these faculty under the supervision of a skillful colonoscopist. A 35 cm. flexible sigmoidoscope with teaching attachment was utilized. This brief, but intensive initial preparation proved adequate to initiate the next phase of the program.

RESIDENT TRAINING

Training in the use of the FFS became a requirement for all residents in this program. Many had expressed interest in acquiring this skill before the training program had begun.

The training was begun with two hours of didactic instruction aided by audiovisual materials which utilized a 35 cm FFS. Audiovisual aides were particularly useful in teaching two techniques for intubation, direct luminal visualization and slide-by (directed by luminal light reflex and following the brighter side of the circular image). Audiovisual aides were again useful in understanding torquing (clockwise and counterwise rotation of the instrument) and dithering, a technique for straightening the recto-sigmoid curve.³ Instruction included proper sterilization, care and storage of the instrument.

* From the Department of Family Medicine, Medical University of South Carolina, 171 Ashley Avenue, Charleston, S. C. 29425 (address correspondence to Dr. Brock).

** Model FPS-3, A-O Reichert Scientific Instrument, Southbridge, MA.

After the above instruction, residents practiced using the FFS by utilizing recto-sigmoid models. Following this hands-on experience, residents observed their faculty member teachers utilize the FFS on patients. The number of observations which preceded participation in flexible sigmoidoscopy varied with previous experience in this procedure elsewhere, manual dexterity and aptitude.

After a few observations, residents were then permitted to extubate the instrument after a faculty member had intubated the patient with the FFS. Extubation (withdrawal) is the easier portion of the exam to master and gives the resident a chance to familiarize himself with the instrument during an examination. When the teacher believed the resident ready, the resident was permitted to introduce the scope, with the teacher at his side. The teaching attachment permitted simultaneous viewing and a continuous dialogue. This made teaching of this procedure easier and perhaps requiring less repetition for competency. Only after a resident demonstrated ample skill to introduce the FFS to 35 cms and carefully observe the bowel lumen on withdrawal, was permission given to perform this procedure alone. This usually followed about three to four smoothly performed sigmoidoscopies.

During the period when residents were learning to utilize the FFS, several conferences were devoted to reviewing the transition of adenomatous polyps to adenocarcinomas, distribution of lesions, and the epidemiology of this disease.

The value of screening and removal of pre-malignant lesions was emphasized as examples of primary and secondary prevention respectively.

NURSING ASSISTANCE

At the beginning of our study period, we had a staff member (a licensed practical nurse) with previous experience in assisting with gastrointestinal endoscopy. However, after a few months into the study period, she transferred to another department and was replaced by a nursing assistant without previous endoscopic experience. Our nursing supervisor worked with us to develop protocols for assisting physicians with FFS which emphasized patient preparation and instrument care. (Appendix 1)

RECRUITMENT OF PATIENTS FOR SIGMOIDOSCOPY

All patients within the at-risk population without a sigmoidoscopic exam in the past twelve months received a written communication encouraging them to have a yearly screening FFS for cancer of the lower colon and rectum. The "at-risk population" was defined as all patients over the age of 50 years registered with this practice who belong to families with at least one member visiting within the past two years (active population). The at-risk population consisted of 1,100 people between ages 50-64 and 966 people 65 years and older. The communication requested that the patient call the Family Medicine Center for hemoccult testing material and for an appointment with his/her physician for a flexible sigmoidoscopic examination. These guidelines are consistent with those set by the American Cancer Society for cancer screening in asymptomatic individuals.⁴ In response to the 2,179 letters that were mailed, 1,097 people requested hemoccult testing material, and 126 patients received FFS.

In addition, there were 31 patients younger than 50 years who received FFS during the study period for a variety of reasons; most commonly for fresh rectal bleeding or heme positive stools.

RESULTS

From July, 1983 to June, 1984, a total of 157 procedures were performed by 26 different physicians. Four of the physicians were faculty members and 22 were residents in training. Apart from one first year resident, the remainder of the residents were in their second and third year of training (eight in the former category and 13 in the latter). The residency program was composed of 15, 14, and 13 residents in the first to third year of training, respectively. Five third year and three second year residents were judged by faculty preceptors to be capable of operating independently by the criteria already mentioned after this one year period. The time taken per procedure ranged from five to 30 minutes with an average of 17 minutes. The distance of intubation per procedure ranged from 15 cms to 35 cms with an average intubation distance of 32 cms.

Table I details the abnormal findings (among eight patients) noted in 157 examinations. One hundred and forty-nine patient examinations

FLEXIBLE SIGMOIDOSCOPY

were normal. Two patients were noted to have small polyps on FFS which were not seen on subsequent colonoscopy. This emphasizes the benefits of photographic documentation of abnormal findings. Our findings are similar to those of others.^{5, 6}

Table II displays the patient's perceptions of comfort or discomfort during flexible sigmoidoscopy; the great majority (76 percent) of patients experienced the procedure as "easy" or causing "mild discomfort only." Thirty-two patients had previously experienced rigid sigmoidoscopy (Table III). The great majority of this group (72 percent) preferred the flexible procedure.

DISCUSSION

The flexible sigmoidoscope allows the physician to screen for colo-rectal cancer more effectively than the rigid sigmoidoscope. Several factors influence its greater effectiveness, namely, its greater length; its greater acceptability by patients (who find it more comfortable than the rigid instrument); and because physicians are more likely to use it.

Training in the technique of flexible sig-

moidoscopy is a desirable goal which has a two-fold objective. In the first instance, the physician learns a valuable manual skill and secondly, he/she learns from direct experience the value of preventive health screening. We believe that practical hands-on experience is a better teacher than the classroom when learning preventive health screening. This is true from the perspectives of patient education, personal professional attitudes, cost/benefit ratio, and the ability to identify a high risk group of patients who can benefit from early detection of their disease process (in this case, colo-rectal cancer or its precursors).

The goals discussed earlier were in large measure achieved. In a relatively short period, a core of trained faculty were available to teach flexible sigmoidoscopy. The issues of patient preparation, instrument storage and cleansing, and nursing assistance during examination were found acceptable to the nursing staff. Resident enthusiasm for the procedure was evidenced by participation of 22 residents (21 of 27 residents in the last two years of training) in the twelve months after this procedure was first introduced. Patient acceptance of the procedure was high. In addition, we were

Table I. ABNORMAL FINDINGS ON FLEXIBLE SIGMOIDOSCOPY

<i>Findings</i>	<i>Number of Patients</i>	<i>Site</i>	<i>Symptoms</i>
Adenomatous polyps	4	10, 10, 15, 22 cms	Asymptomatic
Tubovillous adenoma	1	10 cms	Heme positive stools
Polyps without hystological diagnosis	2	5, 5, 15 cms	Asymptomatic
Adenocarcinoma	1	20 cms	Rectal bleeding
False polyps	2	—	Not seen on colonoscopy

Table II. PATIENT PERCEPTIONS OF FLEXIBLE SIGMOIDOSCOPY

<i>Degree of Comfort</i>	<i>Easy or Mild Discomfort Only</i>	<i>Uncomfortable or Very Uncomfortable</i>	<i>Not Recorded</i>	<i>Total</i>
Number of Patients	110 (76%)	44 (22%)	3 (2%)	157 (100%)

Table III. PREFERENCE OF PATIENTS WHO EXPERIENCED BOTH FLEXIBLE AND RIGID SIGMOIDOSCOPY

<i>Preference</i>	<i>Flexible</i>	<i>Rigid</i>	<i>No Preference</i>	<i>Total</i>
Number of Patients	23 (72%)	4 (12%)	5 (13%)	32 (100%)

satisfied that flexible sigmoidoscopy could be done in the time frame of a routine office visit. After one year's experience, we achieved partial success in training residents to perform flexible sigmoidoscopy independently. Six of the twenty-two residents participating performed five or more flexible sigmoidoscopies in the twelve month period described. Despite this, eight of the twenty-two were felt competent by faculty to perform examinations unsupervised. Additionally, it is our opinion that just a very few additional examinations would qualify many more residents for unsupervised examinations. If introduced at the beginning of a three year residency training period, it is likely that a large percentage of graduates would be skilled in this procedure based on our experience. This has been the experience of others.^{1, 5}

Problems encountered were fortunately small. The initial reticence of the nursing staff to accept responsibility for the care of another piece of equipment and provide time to assist physicians in an already busy schedule was quickly overcome. The gastroenterologists who assisted us with initial training were supportive although they encouraged us to limit ourselves to the 35 cm. instrument. Although patient acceptance for hemoccult testing was fairly good (50 percent), the response to requests for flexible sigmoidoscopy (six percent) was not. Perhaps followup by letter or phone combined with one-on-one patient education from physicians will increase the patient's willingness to undergo this screening examination. Frame demonstrated that he could achieve 75 percent overall patient compliance with hemoccult testing in this way.⁷ Nevertheless, the number of sigmoidoscopies performed increased from 10 to 157 in one year. A critical factor in the relative success we achieved was the active support of the Department Chairman, the Residency Program Director, and the Medical Director of our Family Medicine Center.

Careful comparison of available instruments and their serviceability are important considerations when choosing a flexible sigmoidoscope. A teaching attachment, while invaluable for teaching, probably increased the time taken for examinations and may explain some of the differences in our average length of examination time compared to those previously referenced.

We conclude that physicians previously experienced with rigid sigmoidoscopy can be readily

trained in flexible sigmoidoscopy. Resident physicians can become competent in this procedure after a small number of supervised patient examinations. Nursing staff without prior experience as endoscopy assistants can quickly develop skills needed as endoscopy assistants. Patients undergoing flexible sigmoidoscopy find it an acceptable procedure.

Screening for colo-rectal diseases utilizing the FFS is an effective way to demonstrate secondary health prevention to physicians in training (as well as identifying patients at high risk for carcinoma of the colon). Our findings have shown us that flexible sigmoidoscopy is not a viable alternative to hemoccult testing as a screening method for colo-rectal cancer unless a significant drive for more patient education is undertaken. Physicians training in family medicine, internal medicine, and general surgery should have exposure to similar training opportunities. Similar experiences can be, and increasingly are, offered to practicing physicians as well.

SUMMARY

In July, 1983, a training program in flexible fiberoptic sigmoidoscopy (FFS) was introduced to a Family Medicine Residency Program as a goal with two-fold objectives: to provide a valuable manual skill and to study aspects of preventive health screening. An initial core of two faculty members received training in FFS. After one year, 21 of 27 second and third year residents and two additional faculty members received training in FFS, with a total of 157 patient examinations performed. Protocols for patient preparation and training of nursing assistants were accomplished. Physicians without previous experience in FFS can be readily trained in and administer teaching programs in FFS for residents in training. □

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Appendix 1.

Protocol for Patient Preparation and Scheduling for Flexible Sigmoidoscopy

1. The nursing assistant is informed by physicians, nurses or receptionists of all patients to be scheduled for flexible sigmoidoscopy. When possible, she discusses the procedure with the patient at this time.

2. The nursing assistant calls patients by phone 24 hours before the procedure to give them a reminder and to again explain the bowel preparation (one Fleet's enema one hour before leaving home). No special dietary instructions are given.

3. The patient is scheduled at the center 45 minutes before the procedure is to begin to allow adequate time for further bowel preparation.

4. A second Fleet's enema is given immediately upon arrival to the Center except in the frail elderly or those with completely clear initial return. The patient is encouraged to retain the enema for 15 to 20 minutes. This is repeated only if returns are not clear (about 10 percent of patients).

5. Information about the procedure is given to the patient by the assistant. The patient is shown

the instrument and a diagram of the recto-sigmoid region. The recto-sigmoid junction and the sigmoid curve are discussed as regions which can delay intubation and possibly cause mild discomfort.

6. The patient's signature is obtained for the consent form by the physician and/or assistant. The assistant and resident between them, confirm proper functioning of the sigmoidoscope (suctioning, light, air insufflation and focusing) and teaching attachment.

7. The patient is then positioned in the lateral Sims position for anoscopy and hemoccult testing once the preceptor is introduced to the patient.

8. During the procedure, the assistant helps by being prepared to flush the lens with a hand-held syringe and turn on the suction apparatus when requested. Some residents request her to advance the scope during intubation and to assist them with extubation.

9. When the procedure is completed, the assistant is responsible for sterilizing the instrument. The process of sterilization and returning the equipment for storage takes her a further 20 to 25 minutes for approximately one hour and 15 minutes of nursing assistant time per patient exam. Offices where instrument light source and suction equipment can be left on an open cart without needing to store these elsewhere could save 15 to 20 minutes.

There is a Name for Quality Psychiatric Care

And Here's Where The



CONTINUING MEDICAL EDUCATION PREFERENCES IN SOUTH CAROLINA*

KAY McFARLAND, M.D.**

Late in 1983 and early in 1984, a mail survey was undertaken by the University of South Carolina School of Medicine, the Medical University of South Carolina, and South Carolina Medical Association to determine what type of continuing education activities South Carolina physicians prefer. Two hundred and eighty-seven physicians replied, out of an estimated four thousand physicians in the state. The following tabulations may be of special interest to participants in the study, and those who plan continuing education programs.

The factors which most influence attendance of a particular program were in order: topic, location, and speakers. A lecture format was the most popular type of program with small workshops a distant second. Most physicians preferred programs at a resort on a Saturday.

Some responders checked more than one choice to a question and all choices are recorded. The questions and responses are as follows:

1. FOR SINGLE DAY PROGRAMS — I PREFER THESE HELD ON:

Monday	9
Tuesday	6
Wednesday	25
Thursday	19
Friday	93
Saturday	123
Sunday	30
No Preference	20

2. THE DURATION OF PROGRAMS THAT I PREFER ARE:

One Afternoon	11
One Afternoon and Evening	21
One Full Day	138

One and One-half Days	64
Half-day on Weekend	37
Half-day During Week	18
Other:	
Two Full Days	3
One Hour in a.m.	3
One Full Day on Weekend	3

3. I PREFER THE FOLLOWING FORMAT:

Audiovisual Tape/TV	30
Lectures	200
Miniresidency	18
Panels	34
Patient Presentation	32
Small Workshop	90
Other:	
Combination of Above	3
No Preference	2

4. THE FACTORS WHICH MOST INFLUENCE WHETHER I ATTEND A PARTICULAR PROGRAM ARE:

Cost	47
Location	126
Speakers	104
Topics	193
Sponsor	2
Other:	
Ability to schedule time to attend ..	14

5. I PREFER MEETINGS AT A:

Hospital	58
Medical School	77
Resort	148
Other:	
Location not Specified	7
All Above	11
No Preference	12

6. UNDER WHOSE SPONSORSHIP AND WHERE DO YOU CURRENTLY OBTAIN CME?

County Medical Society	72
State Medical Society	66
Medical School	99

* This report is based on a survey conducted by Dr. McFarland, Dr. James Long of Spartanburg (representing the South Carolina Medical Association), and Dr. Ramsey Mellette of Charleston (representing the Medical University of South Carolina).

** Office of Continuing Medical Education, University of South Carolina School of Medicine, Columbia, S. C. 29208.

CME PREFERENCES

<i>Other:</i>	
State or National Specialty Society . . .	105
Other Source not Specified	38
Hospitals	13
Home Study	3

7. I BELIEVE A FAIR PRICE FOR TUITION PER HOUR IS:

\$-0-	11
\$ 5	40
\$10	121
\$15	41
\$20	21

Other:

No Idea	24
Depends on program	11
Cost of doing	3

8. I PREFER PROGRAMS IN:

Winter	52
Spring	70
Summer	28
Fall	35
No Preference	156

9. SPECIALTIES RESPONDING BY FREQUENCY:

Family Practice	83
Surgery	29
Internal Medicine	20
Pediatrics	18
OB/GYN	18
Radiology	12

Orthopedic Surgery	12
Other Specialties	Less than 7 in number by specialty

10. COUNTIES RESPONDING BY SPECIALITY:

Charleston	40
Richland	34
Spartanburg	30
Greenville	25
Others	9 or less

11. WHAT SUBJECT AREAS WOULD YOU LIKE COVERED AT MEETINGS DURING THE NEXT YEAR?

Allergy	36	Oncology	38
Anesthesiology	11	Ophthalmology	29
Arthritis- Rheumatism	52	Orthopedics	47
Cardiovascular Diseases	63	Otolaryngology	26
Dermatology	65	Pathology	9
Emergency Medicine	45	Pediatrics	57
Endocrinology	65	Psychiatry	38
Gastroenterology	48	Pulmonary Disease	61
Internal Medicine	72	Radiology	28
Neurology	34	Sports Medicine	71
Obstetrics/ Gynecology	33	Surgery	33
		Urology	28

□

FINANCIAL CHECKUP

MARTIN LEFKOWITZ
Certified Financial Planner
Tax Shelter Co-Ordinator: E.F. Hutton

Vol. 4, Issue No. 6

June 1985

CONTINUATION OF

Hold the eulogies--tax-sheltered investments are alive and well.

WHAT CAN WE EXPECT?

As suggested earlier, economics are becoming more and more key in any tax shelter. Fewer so-called "deep shelter" offerings (those that attempt to generate tax deductions of 2:1 or better) are being structured. More and more, investments are trading off heavy tax benefits for cash flow, capital appreciation, or both. In fact, this trend hardly began with the latest Treasury tax proposals: The last several tax revisions enacted by Congress all had the effect of orienting shelters increasingly toward economic benefits and further away from the generation of tax losses.

In sum, "tax shelters" are increasingly being viewed and offered in a more generic way: as direct investments, programs that offer direct participation in a business enterprise whose economics suggest significant returns to investors. The programs are most frequently in real estate, oil and gas, equipment leasing, cable TV and research and development. Choosing an investment program is a matter of establishing where the economics of a business and an investor's personal financial goals best fit together.

To the extent that most deep shelters, especially in real estate, are highly leveraged (the higher the leverage, the greater the tax benefits), there is some trend toward decreasing leverage in tax-advantaged investments.

"Hybrid" products are increasingly being created that combine the advantages of traditional shelters with up-front economics. For example, subsidized housing has always been a real estate investment heavily oriented toward tax advantages. Now, more programs are including both subsidized and conventional housing in the same portfolio, enabling investors to strike a balance in the sources of their potential profits.

Novel partnership structures are being developed to meet a changing environment. For example, a program might be organized not as one limited partnership but as a group of individual investors, each constituting his or her own limited partnership.

Quite apart from any tax reform that may or may not come to pass, new investment opportunities continue to emerge. In light of the country's changing demographics, for instance, miniwarehouses and mobile homes are becoming an important investment area. As cable TV continues to develop, more and more limited partnerships are being structured in that business. And as the high-technology sector keeps churning out projects, investors can expect to see more--and more varied-- R & D investments on the market.

In sum, we are living through changing times. As the tax situation develops and ultimately is resolved, the nature of tax-advantaged investments will necessarily be modified. But there is bound to be strong demand for this product into the foreseeable future -- and some exciting developments as the industry moves forward.

WHAT IS A TRADITIONAL TAX SHELTER?

Although there are several kinds of investments that have tax benefits attached to them, such as municipal bonds and bond funds, tax-exempt trusts, and various annuities, the term "tax shelter" has traditionally denoted a direct investment in a business enterprise that offers tax advantages as part of its earnings potential.

These tax advantages have traditionally taken the form of deferred tax payments, current special tax relief, the treatment of certain profits as long-term capital gain, or any combination of these three. Most deductions available through shelters fall into one or more of the following categories: (1) depreciation (2) current operating expenses (3) interest on partnership borrowings (4) the depletion allowance on energy assets (5) the Investment Tax Credit, an off-the-top tax credit that applies principally to partnerships involved with equipment leasing, the construction of new cable TV systems and the rehabilitation of existing real estate.

Virtually all tax shelters are limited partnerships, and brought to the market either as public offerings - registered with the Securities and Exchange Commission and open to a wide spectrum of investors -- or as private placements. Private placements, which generally are structured to provide more tax write-offs than public offerings, are open to fewer, more sophisticated, and more affluent investors. (Suitability requirements for private placements are generally \$1,000,000 in net worth or \$200,000 in income for the two years prior to partnership formation and expected in the year the partnership forms.) In all tax shelters, at least some of the income generated is shielded from taxation, and in some cases, deductions can actually shield income from additional sources, as well. E.F. Hutton's best projection is that there will continue to be a market for these traditional tax advantages -- when they are energized by the heart of any good direct investment: sound economics.

FURTHER INFORMATION

If you would like to receive further information on any of the topics covered in this newsletter, please write to Martin Lefkowitz, CFP, E.F. Hutton & Company, Inc. 2700 Middleburg Dr., Suite 200, Columbia, SC 29204; or Call (800) 922-1112.

* * * * *

The information contained herein has been obtained from sources believed reliable, but is not necessarily complete and cannot be guaranteed. Any opinions expressed are subject to change without notice. Neither the information presented nor any opinion expressed constitutes a representation by us or a solicitation of the purchase or sale of any securities. South Carolina Medical Association and E.F. Hutton & Company, Inc. 1985.

Editorials

THE BOARD AFFAIR: NO CAUSE FOR EMBARRASSMENT

"It's a tempest in a teapot if ever there was one." In those words, one observer at our recent convention summarized the brouhaha brought about by the state Supreme Court's decision. For the benefit of those who may have been vacationing on another planet, the court ruled that existing methods for recommending physicians for the State Board of Medical Examiners were unconstitutional because the nominations emanated from the SCMA, to which all of our state's physicians do not belong.

By the time this editorial appears in print, the controversy may well appear to have been a tempest in a teapot to most, if not all SCMA members. However, there remains the concern that the publicity generated by the ruling created, in some quarters, a loss of prestige or negative image for our association. Suggestions arose to the effect that the SCMA, although unable to speak for all physicians, has conspired to regulate medicine within South Carolina. Such suggestions are in error.

The State Board of Medical Examiners has always functioned independently of our association. The legislature has passed various acts regulating medical practice since at least 1817; our association dates only to 1848. Eventually, however, it came to be well-recognized that essentially all physicians who worked actively and energetically to advance medical practice within South Carolina belonged to our association. Some time ago, the legislature therefore recommended that nominations to the governor for appointment to the Board should come from the SCMA. This seemed only natural. A similar recommendation, for instance, pertained to the South Carolina Dental Association.

Dr. Julian Price recalls that "this practice simply evolved — there was no desire by the association to dominate the process." He adds that "it was simply a practical matter — there was no mechanism for holding elections by all of the state's physicians." It should also be noted that there has never been a requirement in the SCMA bylaws that persons recommended to the governor by the

SCMA need be SCMA members.

Throughout the recent controversy, the functioning of our State Board has gone unquestioned. In a recent survey of data from the Federation of State Medical Boards, South Carolina ranked eighth (or in the upper 16 percent) among all states in the percentage of physicians subjected to disciplinary action.

Elsewhere, however, we should note that the ability of state medical boards to regulate medical practice is being increasingly scrutinized. Society seems to no longer hold acceptable the notion that "the profession can be trusted to discipline members on the rare occasions when misconduct has occurred." Reacting to these remarks, Dr. Arnold Relman, editor of *The New England Journal of Medicine*, remarked:

"The legal authority for enforcement rests with the state government, but the responsibility and practical initiative rest with the medical profession. Physicians are best qualified to evaluate professional competence, and they are in the best position to recognize deviant medical behavior when it first occurs."

Most of us would, I believe, agree with Dr. Relman's assessment. Most of us would also hold that membership in the state association is a valid benchmark to a physician's willingness to expend large quantities of time and energy to constructive efforts to regulate our profession.

All of us owe a large debt of gratitude to those physicians who have served on our State Board of Medical Examiners and who have made it one of the most effective in the country. All of us should share the concern that many factors, not the least of which is the potential for litigation against the Board and its members, have frequently combined to frustrate the actions of such bodies. By focusing attention on the Board, the recent tempest may, in the long run, prove to have been a blessing in disguise.

— CSB

REFERENCES

1. Waring JI: A Brief History of the South Carolina Medical Association. Charleston: The South Carolina Medical Association, 1948.
2. Price J: Personal communication.
3. Feinstein RJ: The ethics of professional regulation. *N Engl J Med* 312: 801-802, 1985.
4. Relman AS: Professional regulation and the state medical boards (editorial), *N Engl J Med* 312: 784-785, 1985.

OUR EIGHTIETH

This issue marks the eightieth anniversary of continuous publication of *The Journal of the South Carolina Medical Association* — among the oldest journals of its kind. Among the articles in the first issue was a well-written piece by Dr. L. C. Stennis of Greenville entitled: “Physiological Saline Solution: Its Uses and Abuses.” The complexities introduced into medical practice since that first issue on June 21, 1905 hardly need recitation. However, we continue to reflect — from time to time — upon the proper function of a state medical journal.

When the founding of a state journal in South Carolina was proposed at the annual meeting in 1900, the SCMA president urged: “Let us no longer bear the stigma of leaving no record of our deeds.” The editorial board recognized that *The Journal* should be *by* and *for* South Carolina physicians, and stressed “upon every man the importance of contributing his share.” Most articles during those early years were written by practicing physicians; full-time faculties were small or even non-existent.

Gradually, however, an increasing proportion of articles came to be written by physicians be-

longing to medical school faculties or to various state agencies. The number of articles submitted by practicing physicians declined. Dr. Joseph I. Waring lamented this situation in 1971:

“It seems unfortunate that one large group of physicians who seldom publish or write anything are those who are very frequently on the main firing line . . . the individuals primarily in clinical practice . . . approaches should be adopted to tap the wealth of clinical experience and time proven expertise that many practitioners enjoy but which does not become available for others to share. . . .”

Dr. Waring actively encouraged practicing physicians to submit their observations to *The Journal*.

In recent years, our editorial board has reaffirmed the position that a state medical journal should be *by* and *for* the state’s practitioners. We continue to encourage the reporting of original observations by private practitioners. We also welcome articles submitted by faculty physicians, but encourage them to submit review articles relevant to our state’s practitioners rather than articles based on original data. These latter types of articles generally belong in various specialty or subspecialty journals. To our knowledge, the Thomas A. Roe and Shirley W. Roe Awards — given annually to either a practicing physician or an institution-based physician on an alternate basis — make our journal unique. Once more, we exhort to SCMA members that this journal is uniquely your journal.

— CSB

ON THE COVER:

JOSEPH HINSEN MELLICHAMP, M.D.

Described as a magnetic and attractive man, Joseph Hinsen Mellichamp practiced medicine in the Bluffton area of South Carolina prior to and after the Confederate War. Dr. Mellichamp was born in Saint Luke's Parish in South Carolina and raised on his family's property in the James Island area of South Carolina. He was the son of the Reverend Styles and Sarah Cromwell Mellichamp. His father was the preceptor of the institution known as Beaufort College and later the pastor of St. James Church on James Island. Because of his father's love for the outdoor life and nature objects, the young Mellichamp developed an interest in botany and this interest continued throughout his adult life. Dr. Mellichamp was born in 1829 and graduated from the South Carolina College in 1849 and later from the Medical College in Charleston in 1852. He entered the practice of medicine with Dr. Pope following his graduation, but shortly after entering practice he determined that he needed further medical education and he moved to hospitals in Europe, primarily Paris, where he extended his medical training. When he returned to Bluffton he assumed the practice of Dr. Pope and remained there throughout his medical career, except for the time of his service to the Confederacy.

He was described as the type of individual who was without ever a selfish thought or hope of fame, who opened his mind to inexhaustible inspirations of nature and transmitted them into a faith and love that warmed the hearts of those who knew him.

The great Sequoia that Dr. Mellichamp is pictured with on the cover was the reason for his trip to California during his last years. He spent considerable time in the New Orleans area with his only daughter. It was during this time that "to his great delight" he accomplished a visit to California and its "big trees." Dr. Mellichamp contributed significantly to the botanical history of South Carolina and was well published for his observations and descriptions of new botanical findings. Dr. Mellichamp was awarded the honor of having had a plant named Mellichampia in his memory. Dr. Mellichamp died in 1903.

— THOMAS M. LELAND, M.D., Ph.D.

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LETTER TO THE EDITOR

TO THE EDITOR:

The National Diabetes Advisory Board has recently published national standards for diabetes education programs. The development of the national standards for diabetes education represents a nationwide effort to promote quality and consistency in diabetes education. The development of the standards and implementation of a national recognition program for diabetes education would have significant impact on many physician practices which provide diabetes education services.

The enclosed article provides a statement on the purpose of the standards and information on the availability of the national standards for diabetes education. We would like to submit the article for publication in *The Journal*.

We thank you for your cooperation in this matter and look forward to hearing from you soon.

Sincerely,

Belinda McNeal
Project Coordinator
S. C. Diabetes Control Project
Division of Chronic Disease
DHEC
2600 Bull Street
Columbia 29201

SOUTH CAROLINA HEALTH CARE PROVIDERS TO PILOT TEST NATIONAL STANDARDS FOR DIABETES PATIENT EDUCATION

In 1983, the National Diabetes Advisory Board (NDAB) published national standards for diabetes patient education programs. Two South Carolina family practice centers, ten hospitals and three health departments are cooperating with the South Carolina Diabetes Control Project and the

National Diabetes Advisory Board in pilot-testing the national standards for diabetes patient education. The Medical University of South Carolina Department of Family Medicine and Anderson Family Practice Center are implementing the national standards as a part of a nationwide effort to promote quality and consistency in diabetes patient education.

In addition to the standards, the National Diabetes Advisory Board has developed a national system of recognition for diabetes patient education programs that meet the standards. Recognition is a voluntary process through which programs that meet the standards are formally identified for a high level of performance, integrity, and quality.

The pilot test of the standards represents a national effort to upgrade the quality and accessibility of diabetes patient education. The results of the pilot study in South Carolina and other areas of the country will provide valuable information on the feasibility of implementation in an operational setting as well as the basis for modifications in the standards and for required adjustments in the recognition process prior to nationwide implementation. The national recognition program has been scheduled for nationwide implementation during 1986. The implementation of a national recognition program for diabetes education would have significant impact on many physician practices which provide diabetes education.

If you are interested in obtaining a copy of these standards or would like assistance in developing a diabetes education program, contact the South Carolina Diabetes Control Project, 2600 Bull Street, Columbia, South Carolina 29201 or call 758-0338.

Continuing Medical Education

Third Quarter
1985
Calendar

James M. Long, III, M.D., Chairman

Published by the S.C.M.A. Committee on Continuing Medical Education
Post Office Box 11188, Columbia, S.C. 29211

SEPTEMBER

"SCIMER'S THIRD ANNUAL REVIEW AND UPDATE IN MEDICINE"

DATES: Sunday, September 22 - Friday, September 27, 1985
LOCATION: Mariner's Inn on Hilton Head Island, South Carolina
DESCRIPTION: The Third Annual Review and Update in Medicine is offering a multi-disciplinary program emphasizing primary care. This important conference will give participants an opportunity to acquire essential practice skills in carefully planned scientific sessions.
SPONSOR: South Carolina Institute for Medical Education and Research (SCIMER) of the South Carolina Medical Association
AUDIENCE: M.D.'s
FACULTY: Guest Lecturers
CREDIT: 26 hours, AMA Category I, CME Credit.* AAFP Prescribed for.

FEE: \$375.00

CONTACT: Barbara Jean Blanks, Post Office Box 11188, Columbia, S.C. 29211 (803) 798-6207

*The South Carolina Medical Association is accredited by the ACCME to offer programs in Continuing Medical Education that meet the requirements for Category I of the AMA Physician's Recognition Award.

JULY

THURSDAY-SATURDAY JULY 11-13

KIAWAH ISLAND, South Carolina

"CLINICAL OBSTETRICS"

SPONSOR: Medical College of Georgia
DESCRIPTION: Recent diagnostic and therapeutic advances in obstetrical care.
AUDIENCE: M.D.'s
CONTACT: Glen E. Garrison, M.D.
(404) 828-3998
CME CREDIT: 16 Hours AAFP Prescribed

MONDAY-THURSDAY JULY 15-18

HILTON HEAD ISLAND, Hilton Head Inn

"CLINICAL CARDIOLOGY"

SPONSOR: Medical College of Georgia
AUDIENCE: M.D.'s
DESCRIPTION: To provide an update in Clinical Cardiology
CONTACT: Glen E. Garrison, M.D., (404) 828-3998
CME CREDIT: 24.25 Hours AAFP Prescribed

THURSDAY-SUNDAY JULY 18-21

KIAWAH ISLAND, Kiawah Island Inn

"PULMONARY DISEASES"

SPONSOR: Medical College of Georgia
DESCRIPTION: Update on Pulmonary Diseases
AUDIENCE: M.D.'s
CONTACT: Glen E. Garrison, M.D., (404) 828-3998
CME CREDIT: 22.25 Hours AAFP Prescribed

WEDNESDAY-SUNDAY JULY 24-28

KIAWAH ISLAND, East Beach Conference Center

SPONSOR: Medical College of Georgia
DESCRIPTION: Critical Care Medicine
AUDIENCE: M.D.'s
CONTACT: Glen E. Garrison, M.D., (404) 828-3998
CME CREDIT: 29.25 Hours AAFP Prescribed

MONDAY-WEDNESDAY JULY 29-31

KIAWAH ISLAND, East Beach Conference Center

"PEDIATRIC UPDATE - 1985"

SPONSOR: Medical College of Georgia
DESCRIPTION: Update in Pediatric Care
AUDIENCE: Family Physicians & Pediatricians
CONTACT: Glen E. Garrison, M.D., (404) 828-3998
CME CREDIT: 22.25 Hours AAFP Prescribed

AUGUST

THURSDAY-SATURDAY AUGUST 1-3

KIAWAH ISLAND, East Beach Conference Center

SPONSOR: Medical College of Georgia
DESCRIPTION: Update on Genetics and Molecular Diagnosis in Clinical Practice
AUDIENCE: Family Physicians
CONTACT: Glen E. Garrison, M.D., (404) 828-3998
CME CREDIT: 15.5 Hours AAFP Prescribed

FRIDAY-SUNDAY AUGUST 2-4

HILTON HEAD ISLAND, Mariner's Inn

"THE ACUTE M.I."

SPONSOR: International Medical Education Corporation
DESCRIPTION: Enhance skills for the diagnosis of the acute M.I.
AUDIENCE: Primary Care Physicians
CONTACT: Margaret A. Kleiger, (303) 790-8445
CME CREDIT: 13 Hours AAFP Prescribed

MONDAY-FRIDAY AUGUST 5-9

MYRTLE BEACH, Landmark Hotel

"Thirteenth Annual Beach Workshop"

SPONSOR: Bowman Gray School of Medicine
AUDIENCE: Family Physicians and others interested in Internal Medicine
CONTACT: Emery C. Miller, M.D., (919) 748-4274
CME CREDIT: 20 Hours AAFP Prescribed

THURSDAY-SUNDAY AUGUST 8-11

HILTON HEAD ISLAND, Hilton Head Resort

"PEDIATRICS FOR THE PRACTITIONER"

SPONSOR: S.C. Chapter, American Academy of Pediatrics
AUDIENCE: M.D.'s
FACULTY: Vincent A. Fulginiti, M.D.; Martin H. Smith, M.D.; Martha Duke Yow, M.D.
CONTACT: B.J. Blanks, S.C. Chapter AAP, (803) 798-6207

SEPTEMBER

OCTOBER

SUNDAY-THURSDAY

SEPTEMBER 15-19

ISLE OF PALMS, Wild Dunes

"SPORTS MEDICINE UPDATE - 1985"

SPONSOR: MUSC

DESCRIPTION: Topics to be covered include: Evaluation of the Athlete, The Young Athlete, Head and Neck Injuries, Sports and Meniscal Injuries, Diagnosis and Management and Conditioning.

AUDIENCE: Orthopaedic Surgeons, Family Practice, Team Physicians, Athletic Directors and Trainers.

FEE: \$450

FACULTY: Guest and MUSC Faculty

CONTACT: Rosemarie Morwessel, M.D., (803) 792-3934

CME CREDIT: 21.25 Hours AMA Category I, 21.25 Hours AAFP Prescribed, 2.125 Hours CEUs

FRIDAY

SEPTEMBER 20

COLUMBIA, Lecture Hall, USC School of Medicine

"FOUNDERS DAY — MAJOR MEDICAL PROBLEMS 1985"

SPONSOR: USC School of Medicine

DESCRIPTION: The program is an annual scientific event which will focus on topics relating to (1) Bioethics, (2) Artificial Heart, and (3) Bioengineering.

AUDIENCE: M.D.'s, Alumni, Students

CONTACT: Rosalyn D. Taylor, M.D., (803) 765-6116

FACULTY: Allen Lansing, M.D., KY; Tom L. Beauchamp, M.D., Georgetown University

CME CREDIT: 4 Hours AMA Category I, 4 Hours AAFP Prescribed

SATURDAY

SEPTEMBER 21 8:00 a.m. - 4:15 P.M.

COLUMBIA, Marriott Hotel

"GASTROENTEROLOGY UPDATE 1985"

SPONSOR: USC School of Medicine and Dorn VA Hospital

AUDIENCE: Primary Care Physicians and Gastroenterologists

CONTACT: John Orchard, M.D., (803) 776-4400 Ext. 264

DESCRIPTION: Complications of Chronic Liver Disease Overview of Hepatitis, Update on Bowel Diseases, Infectious Diarrhea-Gay Bowel Syndrome Hemocult Testing and Flexible Signoidoscopy

FEE: \$50 M.D.'s — \$20 Residents, Nurses and GI Assistants

FACULTY: Guest and Staff

CME CREDIT: 6 Hours AMA Category I, 5 Hours AAFP Prescribed, .60 Hours CEU

THURSDAY-SATURDAY

SEPTEMBER 26-28

HILTON HEAD ISLAND, InterContinental Hotel

"FIFTH ANNUAL CONFERENCE FOR TRUSTEES, PHYSICIANS AND ADMINISTRATORS"

SPONSOR: SCMA/SCHA

AUDIENCE: M.D.'s Hospital Trustees and Administrators

CONTACT: Linda Haines, Hospital Association, (803) 796-3080

FRIDAY-SATURDAY

SEPTEMBER 27-28

CLEMSON, Ramada Inn

"CME 'Sym-PAWS-lum' 1985"

SPONSOR: Clemson and MUSC Physician Alumni

DESCRIPTION: Discussion concerning the diagnosis and treatment of current medical topics of interest to the general physician.

AUDIENCE: M.D.'s

CONTACT: R. Ramsey Mellette, M.D./Carole Smith (803) 792-4435

FEE: \$100

FACULTY: Guest and MUSC Faculty

CME CREDIT: 7 Hours AMA Category I, 7 Hours AAFP Prescribed, .7 CEUs

THURSDAY

OCTOBER 3

COLUMBIA, Carolina Inn

"SEMINAR ON PREVENTION OF CHILD ABUSE AND NEGLECT"

SPONSOR: SCMA, S.C. Medical Association Auxiliary, S.C. Chapter Pediatrics and S.C. Chapter Family Practice.

DESCRIPTION: The program will include a discussion of legal issues, importance to physicians and a panel discussion. The panel will be made up of local experts in the field of child protection.

AUDIENCE: Physicians and Spouses and other interested parties.

FACULTY: Robert W. tenBensel, M.D., Professor, University of Minnesota

CONTACT: Donna Murphy, (803) 798-6207

FEE: \$25 Per Participant, \$15 Physician and Spouse, Interns and Residents

CME CREDIT: Available

THURSDAY-SATURDAY

OCTOBER 24-26

HILTON HEAD ISLAND, Hyatt

"SC/NC Societies of Ophthalmology, 1985 Annual Scientific Session"

SPONSOR: SC/NC Ophthalmology Societies

AUDIENCE: Ophthalmologists

CONTACT: B.J. Blanks, (803) 798-6207

FACULTY: J. Lawton, M.D., George Waring, M.D. and Joseph Flanagan, M.D.

CME CREDIT: 6 Hours AMA Category I

GRAND ROUNDS U.S.C. School of Medicine

1st and 3rd MONDAYS 3:00-4:00

GASTROINTESTINAL RADIOLOGY CONFERENCE

COLUMBIA, VA Radiology Dept. Conference IC 209, VA Hospital
SPONSOR: USC School of Medicine, Dept. of Radiology and Gastroenterology and Division of Internal Medicine

DESCRIPTION: One-half of the conference will be a discussion and review of a specific subject. The second half will be devoted to current case material with both radiographic and endoscopic findings.

AUDIENCE: Radiologists, Gastroenterologist and other interested physicians

CONTACT: James J. Farrell, M.D., (803) 733-3295

FACULTY: USC School of Medicine, Dept. of Radiology; Division of Gastroenterology, Internal Medicine and Guest Speakers

CME CREDIT: 1 Hour AMA Category I per session

MONDAYS

7:00 A.M.

ORTHOPAEDIC GRAND ROUNDS

COLUMBIA, Richland Memorial Hospital - 1st Floor

CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

MONDAYS

4:00 P.M.

BASIC SCIENCES SEMINAR SERIES

CONTACT: Philip Watson, PhD, (803) 733-3242

MONDAYS-THURSDAYS 12:00-1:00 P.M.

INTERNAL MEDICINE LECTURE SERIES

Richland Memorial Hospital 7 West Classroom

CONTACT: J. O'Neal Humphries, M.D., (803) 765-6563

2st & 3rd MONDAYS

12:30 P.M.

G.I. JOURNAL CLUB

Dorn Veterans' Hospital Room 5A127

CONTACT: John Orchard, M.D., (803) 776-4000 Ext. 673

MONDAYS, TUESDAYS, & WEDNESDAYS 12:00-1:00 P.M.
FAMILY PRACTICE CONFERENCE
COLUMBIA, Richland Memorial Hospital, Large Dining Room of the Cafeteria—Mondays—Family Practice Conference Room—Tuesdays and Thursdays
SPONSOR: Dept. of Family Practice, USC School of Medicine
AUDIENCE: Family Practice and Internal Medicine Physicians and Medical Students
CONTACT: Roslyn D. Taylor, M.D., (803) 765-6118, Dept. of Family Medicine Richland Memorial Hospital, Columbia, SC
FACULTY: Dept. of Family Medicine and Internal Medicine, USC School of Medicine
CME CREDIT: 1 Hour AMA Category I per session

TUESDAYS 7:00 A.M.
BASIC SCIENCE & PATHOLOGY ASPECTS OF ORTHOPAEDICS
 Richland Memorial Hospital - Radiation Therapy Conference Room
CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

2nd & 4th TUESDAYS 12:00 NOON
PATHOLOGY G.I. CONFERENCE
 Dorn Veterans' Hospital, Room 1A172
CONTACT: John Orchard, M.D., (803) 776-4000, Ext. 673

3rd TUESDAYS 12:30 P.M.
OB/GYN GRAND ROUNDS
COLUMBIA, Richland Memorial Hospital
SPONSOR: USC Dept. of OB/GYN, RMH, MUSC, Spartanburg and Greenville
DESCRIPTION: One of a series of live interactive broadcasts over the HCN, a statewide closed circuit TV network for CME in OB/GYN.
CONTACT: Ronald B. Wade, M.D., (803) 765-7156
FEES: None
CME CREDIT: 1 Hour AMA Category I (per session)

1st, 2nd & 4th TUESDAYS 1:00 P.M.
PEDIATRIC GRAND ROUNDS
COLUMBIA, Richland Memorial Hospital
SPONSOR: USC School of Medicine, Dept. of Medicine
CONTACT: Warren Derrick, M.D., (803) 765-7211
CME CREDIT: 1 Hour AMA Category I (per session)

WEDNESDAY 12:00 NOON
PSYCHIATRY GRAND ROUNDS
 Hall Institute Form
CONTACT: Bonnie Ramsey, M.D., (803) 758-8052
CME CREDIT: 1 Hour AMA Category I (per session)

2nd & 4th WEDNESDAYS 12:00 NOON
PULMONARY MEDICINE CHEST CONFERENCE
 Richland Memorial Hospital, 7th Floor Conference Room
1st & 3rd THURSDAYS 12:00 NOON
 7th Floor Conference Room, Dorn Veterans' Hospital
CONTACT: Gerald N. Olsen, M.D., (803) 733-3112

WEDNESDAYS 6:00 P.M.
ORTHOPAEDICS PROBLEM CONFERENCE
 Richland Memorial Hospital Conference Room "P", ACC II
CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

THURSDAYS 10:00 A.M.
HEMATOLOGY/ONCOLOGY GRAND ROUNDS
 Dorn Veterans' Hospital, 5-West Classroom
CONTACT: George P. Satiano, M.D., (803) 733-3112

5th THURSDAY 12:00 NOON
G.I. RESIDENTS CONFERENCE
 Dorn Veterans' Hospital, 4th Floor Conference Room
CONTACT: John Orchard, M.D., (803) 776-4000, Ext. 673

1st THURSDAYS 4:00 P.M.
RADIOLOGY DEPT. CONTINUING EDUCATION CONFERENCE
 USC School of Medicine Library Bldg., Room B-116
CONTACT: David F. Adcock, M.D., (803) 733-3295
CME CREDIT: 1 Hour AMA Category I

THURSDAYS 4:00 P.M.
ENDOCRINE CASE PRESENTATION
 USC School of Medicine Administration Bldg. 2nd Floor Conference Room
CONTACT: Juraj Osterman, M.D., (803) 733-3112

FRIDAYS 7:00 A.M.
ORTHOPAEDIC SUB-SPECIALTY TOPICS
 Richland Memorial Hospital - Large Private Dining Room
CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

FRIDAYS 9:00-11:30 A.M.
PREVENTIVE MEDICINE GRAND ROUNDS
 USC School of Medicine Library Bldg. Room 327
CONTACT: Alan Chovil, M.D., (803) 733-3306
CME CREDIT: 2 Hours AMA Category I

FRIDAYS 1:00 P.M.
INTERNAL MEDICINE GRAND ROUNDS
COLUMBIA, Richland Memorial Hospital Auditorium
SPONSOR: Dept. of Medicine, USC School of Medicine
AUDIENCE: Internal Medicine and Family Practices Physicians
CONTACT: J. O'Neal Humphries, M.D., Chairman, Dept. of Medicine, (803) 765-6563
CME CREDIT: 1 Hour AMA Category I

SATURDAYS 9:00-10:00 A.M.
SURGICAL GRAND ROUNDS
COLUMBIA, Richland Memorial Hospital Auditorium
SPONSOR: USC School of Medicine, Dept. of Surgery
DESCRIPTION: Lectures and case presentations given by the department staff and guest speakers
AUDIENCE: Faculty, Residents, Students and Private Clinicians
CONTACT: Carl H. Almond, M.D., (803) 254-4158; James L. Haynes, M.D., (803) 765-7452; Frederick L. Greene, M.D., (803) 776-4000, Ext. 582
FACULTY: Staff of Dept. of Surgery and guest lecturers
CME CREDIT: 1 Hour AMA Category I (per session)

GRAND ROUNDS

Medical University of South Carolina

MONDAYS 9:30 A.M.
PATHOLOGY - Surgical Pathology Conference
CONTACT: Drs. Betsill, Garvin, and Metcalf, (803) 792-3821

EACH MONDAY 12:00 NOON
UROLOGY - Clinical Sciences Bldg. Suite 644
CONTACT: Dr. Stepheyn N. Rous, (803) 792-4531

MONDAYS 12:30-1:30 P.M.
RADIOLOGY - Noon Conference
CONTACT: Dr. E.Q. Seymour, (803) 792-4261

MONDAYS 4:00-5:00 P.M.
RADIOLOGY - Special Imaging Conference
CONTACT: Dr. E.Q. Seymour, (803) 792-4261

EVERY OTHER MONDAY 10:00 A.M.-12:00 NOON
PATHOLOGY - Pathology Microscopic Round Table Conference
CONTACT: Dr. Gordon Hennigar, (803) 792-3121

MONDAY-FRIDAY
RADIOLOGY - Visiting Radiologist
CONTACT: Dr. E.Q. Seymour, (803) 792-4261

TUESDAYS 7:00 A.M.
SURGERY - Cancer Conference/Surgical Grand Rounds
CONTACT: Drs. Anderson and O'Brien, (803) 792-3361 or 3276

TUESDAYS 7:00-8:00 A.M.
ORTHOPAEDIC SURGERY - Orthopaedic Grand Rounds
CONTACT: Dr. John B. McGinty, (803) 792-3934

TUESDAYS 8:00-10:00 A.M.
PATHOLOGY - Seminar-Tutorial Group Sessions, Systemic Path.
CONTACT: Dr. Jane Upshur and Dr. Gordon Hennigar, (803) 792-2456

TUESDAYS 8:30-9:30 A.M.
OB/GYN - Morning Conference
CONTACT: Dr. Peter Van Dorsten, (803) 792-2684

TUESDAYS 9:00-10:00 A.M.
MEDICINE - Medical Grand Rounds
CONTACT: Dr. Jon J. Levine and Dr. James Allen, (803) 792-2528

TUESDAYS 11:00 A.M.-Noon
LABORATORY MEDICINE - Laboratory Medicine Case Presentation
CONTACT: Elena Prevost, (803) 792-3937

TUESDAYS 11:00 A.M.-NOON
PSYCHIATRY - Departmental Grand Rounds
CONTACT: Dr. R.R. Mellette, Jr., (803) 792-4037

TUESDAYS 12:30-1:30 P.M.
OB/GYN - TV Grand Rounds
CONTACT: Julia Day, Division of Continuing Education, (803) 792-4435

TUESDAYS 1:00-2:00 P.M.
PATHOLOGY - OB/GYN Pathology
CONTACT: Dr. John Metcalf, (803) 792-4050

TUESDAYS 2:00-3:00 P.M.
PSYCHIATRY - Case Conference
CONTACT: Dr. Thomas Steele, (803) 792-4050

TUESDAYS 4:00-5:00 P.M.
PATHOLOGY - Orthopaedic Pathology Conference
CONTACT: Dr. A.J. Gavin, (803) 724-2258, Ext. 2260

TUESDAYS 4:00-5:00 P.M.
SURGERY - Surgical Seminar Series
CONTACT: Dr. Max S. Rittenbury, (803) 792-3251

1st & 3rd TUESDAYS 4:00-5:00 P.M.
PATHOLOGY - Gastrointestinal Pathology Conference
CONTACT: Dr. Francis M. Brown, (803) 577-5011, Ext. 566

2nd & 4th TUESDAYS 1:30-3:00 P.M.
PSYCHIATRY - Case Conference/VA
CONTACT: Dr. James D. Sexauer, (803) 577-5011, Ext. 234

2nd & 4th TUESDAYS 4:00-5:00 P.M.
PATHOLOGY - Renal Conference
CONTACT: Dr. Sterling K. Ainsworth, (803) 792-4171

WEDNESDAYS 9:00-10:00 A.M.
PATHOLOGY - Graduate Medical Education in Pathology
CONTACT: Dr. Gordon Hennigar, (803) 792-3121

WEDNESDAYS 12:10-1:10 P.M.
FAMILY MEDICINE - Family Medicine Noon Conference Series
CONTACT: Dr. Ben Goodman, (803) 792-2411

WEDNESDAYS 1:00-2:00 P.M.
LABORATORY MEDICINE - Clinical Pathology Conference/VA
CONTACT: Dr. Jerome L. Sullivan, (803) 577-5011, Ext. 466.

WEDNESDAYS 3:00-4:00 P.M.
LABORATORY MEDICINE - Hematology Conference
CONTACT: Rebecca E. Reynolds, MT(ASCP)SH, (803) 792-2933

WEDNESDAYS 3:00-4:00 P.M.
PATHOLOGY - Charleston Veterans Administration Medical Center
Tumor Board
CONTACT: Dr. Helen M. Dodds, (803) 577-5011, Ext. 466.

WEDNESDAYS 6:00-7:00 P.M.
RADIOLOGY - Low Country Ultrasound Society
CONTACT: Dr. Stephen I. Schabel, (803) 792-4261

WEDNESDAYS 7:30-8:30 P.M.
OB/GYN - Monthly Journal Club Meeting
CONTACT: Dr. Oliver Williamson, (803) 792-2864

Last WEDNESDAY of the month 9:00-11:00 A.M.
PATHOLOGY - Grand Rounds
CONTACT: Dr. J.D. Balentine, (803) 792-3581

THURSDAYS 8:30-10:00 A.M.
PSYCHIATRY - Medicine Teaching Case Conference, Consult/
Liaison Service
CONTACT: Dr. Oliver Bjorksten, (803) 792-2971

THURSDAYS 8:30-9:30 A.M.
PATHOLOGY - Surgical Pathology Conference
CONTACT: Drs. Betsill, Garvin and Metcalf, (803) 792-3821

THURSDAYS 8:30-10:00 A.M.
PSYCHIATRY - Psychiatry Youth Conference
CONTACT: Dr. Donald J. Carek, (803) 792-3051

THURSDAYS 8:30-9:30 A.M.
RADIOLOGY - Teaching Conference in Neuroradiology
CONTACT: Dr. Paul Ross, (803) 792-4267

THURSDAYS 9:30-10:30 A.M.
NEUROSURGERY - Neurosurgery Clinical Conference
CONTACT: Dr. P. Perot, (803) 792-2421

THURSDAYS 9:30-10:30 A.M.
SOCIAL WORK - Pediatric Burn Team Meeting
CONTACT: Elena Bell, (803) 792-3846

THURSDAYS 10:30-11:30 A.M.
NEUROLOGY - Neurology Grand Rounds
CONTACT: Dr. Edward L. Hogan, (803) 792-3221

THURSDAYS 10:30-11:45 A.M.
NEUROSURGERY - Neurosurgery Lecture
CONTACT: Dr. P. Perot, (803) 792-2421

THURSDAYS 12:10-1:10 P.M.
FAMILY MEDICINE - Family Medicine Grand Rounds
CONTACT: Dr. Ben Goodman, (803) 792-2411

THURSDAYS 1:00-2:00 P.M.
PATHOLOGY & DERMATOLOGY - Dermatopathology Conference
CONTACT: Dr. John C. Maize, (803) 792-5858

THURSDAYS 4:00-5:00 P.M.
SURGERY - Junior House Officer Conference
CONTACT: Dr. Marion C. Anderson, (803) 792-3961

1st or 2nd THURSDAYS 11:45-12:45 P.M.
PATHOLOGY - Neuropathology Conference
CONTACT: Dr. J. Douglas Balentine, (803) 792-3581

2nd, 4th & 5th THURSDAYS NOON
FAMILY MEDICINE - Noon Conference
CONTACT: Dr. Ben Goodman, (803) 792-2411

MONTHLY 2:30-3:30 P.M.
LABORATORY MEDICINE - Immunohematology Journal Club
CONTACT: Margaret J. Simmons, MT(ASCP) and Mary A. Spivey, MT(ASCP)SBB, (803) 792-2671

FRIDAYS 8:30-10:00 A.M.
MEDICINE/ENDOCRINOLOGY - Endocrinology Journal Club/
Endocrinology Research Conference
CONTACT: Dr. Maria F. Lopes-Virella, (803) 792-2528

FRIDAYS 8:30-9:30 A.M.
PATHOLOGY - Surgical Pathology Conference
CONTACT: Drs. Betsill, Garvin, and Metcalf, (803) 792-3821

FRIDAYS 8:30-9:30 A.M.
PEDIATRIC - Pediatric Grand Rounds/Case Conferences
CONTACT: Dr. Milton Westphal (803) 792-2113 and Dr. Ashby Taylor (803) 792-3291

FRIDAYS 10:00-11:30 A.M.
PSYCHIATRY - Teaching Case Conference, Adult Inpatient
CONTACT: Dr. Gordon Trockman, (803) 792-3051

FRIDAYS 12:00-1:00 P.M.
PATHOLOGY - Clinico-Pathologic Conference
CONTACT: Dr. R.A. Harley, (803) 792-4444

FRIDAYS 12:10-1:10 P.M.
FAMILY MEDICINE - Noon Conference Series
CONTACT: Dr. Ben Goodman, (803) 792-2411

FRIDAYS 1:00-2:00 P.M.
LABORATORY MEDICINE - Clinical Microbiology Conference
CONTACT: Dr. John Manos, (803) 792-2984

FRIDAYS 4:00-5:00 P.M.
SURGERY - Surgical Services Conference
CONTACT: Dr. Marion C. Anderson, (803) 792-3961

FRIDAYS 4:00-5:30 P.M.
MEDICINE/ENDOCRINOLOGY - Endocrinology Case Conference
CONTACT: Dr. J.A. Colwell, (803) 792-2528

SATURDAYS 9:00-10:00 A.M.
SURGERY - Cancer Conference
CONTACT: Dr. Paul O'Brien, (803) 792-3276

SATURDAYS 10:00-11:00 A.M.
SURGERY - Surgical Grand Rounds
CONTACT: Dr. Marion C. Anderson, (803) 792-3961

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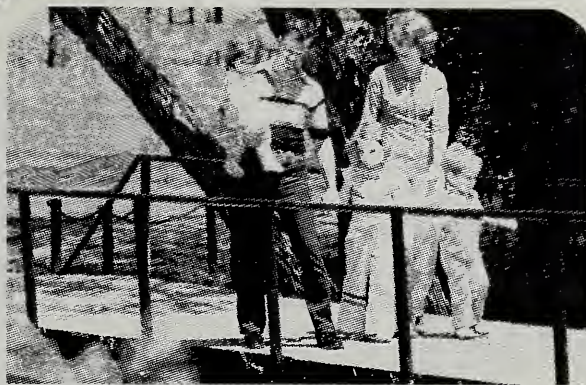
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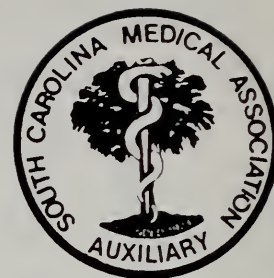
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SOUTH CAROLINA MEDICAL ASSOCIATION AUXILIARY



REWARDS AND CHALLENGES — SOME PARTING REMARKS

Serving as President of the American Medical Association Auxiliary this year has been challenging and rewarding. I have been proud to represent this organization and, yes, South Carolina.

By the end of June, I will have visited approximately 40 states and traveled almost 250,000 miles in the last two years. I see the changes that are taking place in the practice of medicine. I have witnessed the economic changes across this country that are also affecting the physicians. What, then, is the message I have been taking to our members and the medical associations?

The message to the physicians is that we share your concerns for the medical profession today. We are very much aware of the challenges that face you: growing government involvement, myriad alternatives for the delivery of care, competition for patients and increasing threat of malpractice litigation. And we know that these and other factors are combining to change the way medicine is practiced in this country. They are bringing pressures to bear on the medical profession that we have never seen before — pressures that are felt throughout the medical community by spouses and families, as well as physicians.

As members of the AMA Auxiliary, we have no illusion that we can reverse the changes that are occurring. However, as a nationwide network of physicians' spouses, we believe that we have a role to play in helping to assure that these changes will not erode the traditions and the values in which you — and we — believe. We see our role as one of communication, action and support: communication to make every physician's spouse in this nation knowledgeable about the issues that surround the changing environment of medicine; action to ensure that medicine's voice is heard equally with those of others; and support to help physicians and their families withstand the pressures that result from the changes in medicine today.

We are uniquely qualified to carry out these programs. We have a communication network throughout this nation through state and county auxiliaries. We are able to reach our members, your spouses, with important information tailored to their needs. Our magazine, *Facets*, reaches all 80,000 members with news of socioeconomic issues. We provide our leaders with AMA publications to keep them knowledgeable. We hold educational sessions at national meetings on legislative and other issues. Our national board members and committee chairmen take the message to state and county auxiliary meetings. These communications mechanisms help our members to become knowledgeable, but more than that, to *act* knowledgeably.

For as much as our members want and need to know the facts, they also want and need to be active participants in telling medicine's story. AMA Auxiliary members are your best public relations people because we are your most ardent supporters. This year, we have focused on improving relations with media contacts. We know that as the media more and more become the channels of communications for the nation, they are vital to helping improve the image of physicians and the medical profession.

We have also asked our members to increase their legislative involvement, lending support to key contact and legislative alert programs when their medical societies request it.

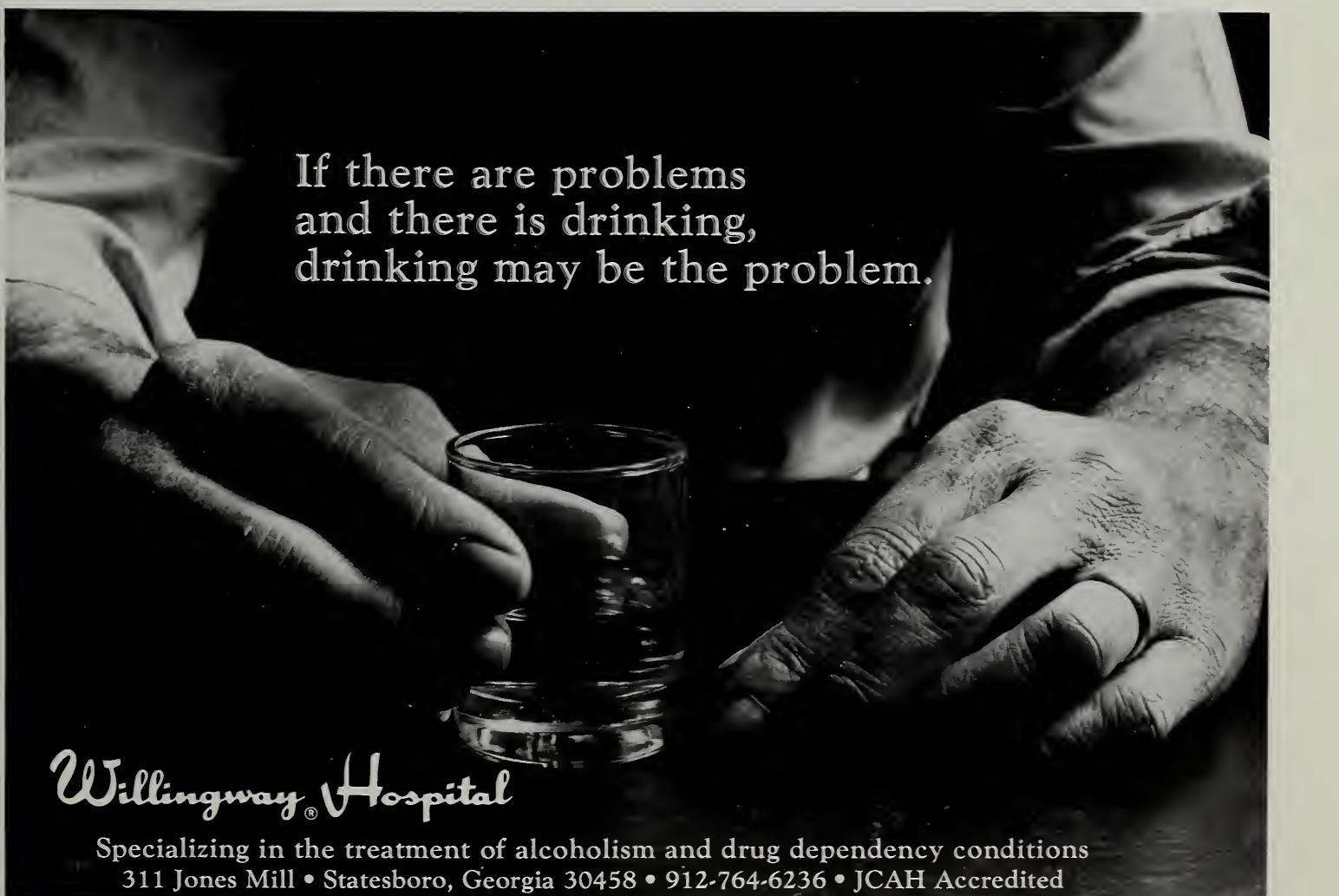
Communication and action are important. But in today's world, there is a need for an activity of a more personal nature — a need for support for physicians and their families. We have broadened the base of our support programs for the spouses and families of impaired physicians, to include help for those who feel

the pressures of today in their home life and for those faced with the threat of malpractice litigation and the emotional impact that accompanies it. Our Auxiliaries have begun support groups to provide crisis help. They are publishing booklets with information on malpractice. They are holding educational sessions to help both physicians and spouses learn about malpractice litigation and how to prevent it.

These are important roles for Auxiliary members to play. We continue to focus on assuring good health in our communities. We continue concerned efforts to raise funds for medical students and schools through AMA-ERF activities. But we believe that we must also direct our efforts to responding to the forces that impact on medical practice today.

We are proud that we can stand side by side with you in seeking to protect the values in which we believe. We thank you for your support, your guidance, your leadership. We could not do our work without it. We ask that it continue so that together the medical profession and all of the medical family will face the challenges of today positively for the betterment of all we seek to serve.

MRS. WAYNE C. (Billie) BRADY
President, American Medical Association Auxiliary
1984-1985



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ON THE COVER: AN HISTORICAL SKETCH OF PROCTOLOGY FROM ANCIENT EGYPT TO MODERN SOUTH CAROLINA

The Chester Beatty Medical Papyrus is the earliest known treatise completely devoted to anorectal disease. Written in hieratic in the twelfth or thirteenth century B. C. this document reminds the present generation that anorectal diseases have troubled people for a long time, calls attention to the antiquity of proctology and testifies to the quality of ancient Egyptian medicine, and serves as a baseline to judge our own progress in proctology.

Papyrus VI of the Chester Beatty Papyri (Papyrus No. 10,686 of the British Museum, which is pictured on the cover) described 41 remedies, suggesting prescriptions with instructions for treating various disorders of the anorectum.¹ For pruritus ani, the Papyrus listed no less than 10 remedies. No single remedy was consistently effective, and today this remains true; over the centuries pruritus ani has successfully defied a satisfactory cure. For hemorrhoidal swelling, the papyrus recommended medications applied in the form of dressings. This and other Egyptian papyri mentioned enemas and suppositories, both still in fashion today. Also, the papyrus recommended fruits such as figs, dates and raisins, as well as senna, castor oil, and colocynth for people who wanted to unload their colons. These practices continue to influence present-day medicine.

The ancient Egyptians valued highly the management of anorectal diseases. Diegpen, the great German medical historian wrote: "In contrast to the popular contempt in which the anus is held today, it must have been an especially esteemed organ in Ancient Egypt."²

In some ways Egyptian medicine was highly developed. Hygiene was emphasized and so was cleanliness. About the same time period in Mesopotamia and in Babylonia a high quality of medicine was also practiced. However, we know more about proctology in Egypt than in these other countries.

In the course of historical events, medical and proctologic knowledge was transferred and adapted by Jews, Greeks, and Romans. During the Dark Ages in Europe, the spread of Arabs through North Africa brought them into contact with the Hippocratic writings. In time the excellent Arabian medicine was brought to Salerno, in southern

Italy. Later, medical learning spread to Bologna, Padua, Montpellier, Paris, and the Low Countries.

In time, Edinburgh, which was a famous medical center, influenced medical thought in South Carolina. In 1968, Dr. J. Hampton Hoch, Professor of Biology and Pharmacology at the Medical University of South Carolina, privately published a monograph "An Academic Genealogy of First Faculty of the Medical College of South Carolina" in which he traced the academic forbears of the founders of this medical school. These gentlemen were influenced by physicians who studied at Edinburgh, who in turn inherited medical thoughts from those in Leyden, Paris, Montpellier, Padua, and Bologna. In their turn, these physicians presumably had some influence on succeeding generations of students.

In 1835, London, Frederick Salmon, a little known surgeon, established the institution that originally was called "The Infirmary for the Relief of the Poor Afflicted with Fistula and Other Diseases of the Rectum." Later, the name was changed to St. Mark's Hospital for Fistula and Other Diseases of the Rectum. This hospital became, and still is, the mecca for anyone interested in studying coloproctology. Because of its high standards of clinical practice and research, St. Mark's Hospital has influenced a large number of Americans, some of whom were encouraged to specialize in proctology. One American surgeon, Dr. Charles Boyd Kelsey, was so impressed by St. Mark's that he founded the St. Paul's Infirmary for Hemorrhoids, Fistula, and Other Diseases of the Rectum in New York in 1879. Because of financial difficulties, the St. Paul's Infirmary was short-lived. Kelsey, however, wrote a treatise on proctology which went through six editions, a lasting testimony to its worth and acceptance.

In those times, general practitioners tended to avoid examinations of the anorectum. In his 1909 presidential address to the American Proctologic Society, Dr. George B. Evans declared: "A few of us, at least, can remember when it was a rule among general practitioners to make no special effort to determine the pathology of diseases of the rectum; in fact, it was believed unbecoming the dignity of a high-class, high-toned medical gentleman to so lightly esteem modesty as to ask the privilege of seeking the naked truth."

In 1899, largely through the efforts of Dr. William M. Beach, Thomas Charles Martin, and Samuel T. Earle, the American Proctologic Society was organized to promote research and study of diseases of the anus, rectum and colon. This organization did much to change attitudes of the medical profession toward anorectal disease. The organization developed, expanded, and promoted residencies in colon and rectal surgery. A few years ago, its name was changed to the American Society of Colon and Rectal Surgeons.

In South Carolina, one of the early physicians to specialize in proctology was Dr. William Thomas Brockman. Born in 1881, at Reidville, in Spartanburg County, Dr. Brockman was in general practice for 14 years. Then he became concerned with the need for proper proctologic treatment among his patients. After he took some short courses, he moved to Greenville, where his reputation grew. Dr. Tom became a fellow of the American Proctologic Society, Chairman of the Section of Proctology of the Southern Medical Association, and enjoyed the unusual distinction of serving two years as president of the South Carolina Medical Association. His obituary in *The Journal of the South Carolina Medical Association* (February, 1969) noted that, "Dr. Brockman was a medical leader, a man of much magnetism, a kindly friendly person with a profound concern with religion and civic affairs. Many people sought his wise counsel on many subjects." Dr. Tom meant a lot to me. He encouraged me in proctology, introduced me to the American Proctologic Society, and had a considerable influence on my career in medicine.

Another pioneer in the specialty of gastroenterology and proctology in South Carolina was Dr. Frank Durham. Born September 25, 1875, near Blackstock in Fairfield County, S. C., Dr. Durham volunteered and served in the Spanish American War. Graduated from the Medical College of South Carolina in 1903, he served in numerous capacities in the South Carolina Medical Association and was president of the Columbia Medical Society. Struck by a passing car while coming from a patient's house, he died January 28, 1935.

Another South Carolinian who specialized in proctology was William Henry Poston. Born in 1881, he graduated from the Medical College of the State of South Carolina in 1909, and practiced in Pimlico in Florence County. During World War II many Charleston Naval Shipyard workers

would car-pool to Dr. Poston for injection treatment of their hemorrhoids.

There have been other physicians in South Carolina who specialized in and promoted proctology. The names of Doctors Carl A. Sweatman, William H. Folk, and W. Clough Wallace come especially to mind. In the past ten years, there has been an increase in the number of physicians specializing in proctology. In 1985, there are nine members (one of whom has retired) of the Society and Colon and Rectal Surgeons.

Now more South Carolina physicians are taking a greater interest in anorectal disease. This is good. South Carolina physicians should be knowledgeable about the organ of continence so as to take better care of their patients' social security.

LEON BANOV, JR. M. D.

ACKNOWLEDGEMENT

Grateful appreciation is expressed to the Trustees of the British Museum for their permission to print the cover photograph.

REFERENCES

1. Banov, L., Jr.: The Chester Beatty Medical Papyrus: The earliest known treatise completely devoted to anorectal diseases. *Surgery* 58: 1037-1043, 1965.
2. Dieggen, P. *Das Analzapschen in Der Geschichte Der Therapie*. Stuttgart, George Thieme Verlag, 1953, p 9.



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President's Page



MEDICARE FEE FREEZE: A SHAM ON THE PUBLIC

As I write this President's Page, it appears certain that the mandatory fee freeze for the care of Medicare beneficiaries will be extended another year — to October, 1986. In all probability this freeze on physician charges will extend to both "participating" and "non-participating" physicians.

The entire concept of this Medicare fee freeze is grossly unfair for many reasons. Most importantly, it is unfair to the Medicare beneficiaries, the elderly and disabled, for many times they are the ones who ultimately suffer the consequences. It is unfair in that it singles out one segment of society, *physicians*, on whom to impose a fee freeze of over two years — discriminatory, to say the least. No other industry in America is laboring under such a freeze. The AMA position is that a freeze will be supported only if "Congress legislates an across-the-board freeze of all domestic and defense spending. . .". SCMA supports this position.

As you are aware, many physicians simply cannot accept Medicare reimbursement as payment in full for their services. They would have to "close their doors." In recent discussions with AMA officials in Washington, I was told that particularly hard hit are primary care physicians, such as family practitioners and internists. With reimbursement at 80 percent of the 1982 allowable charges, they cannot operate a practice. At this level no other business could either!

So what happens? Many physicians elect not to become so-called "participating physicians." Most of them do accept assignment on a "case-by-case" basis. Where there is financial need, the Medicare reimbursement is accepted as full payment. This is responsible action on the part of physicians. As I have stated to the press previously, physicians have historically accepted decreased fees or no fees at all in cases of financial hardship. SCMA encourages this action.

In essence, Congress and the Reagan Administration have forced upon the public a "two-tiered" health care system in America. Rationing, if you will. There is no way to deny this fact. In discussing the matter with physicians in South Carolina, I find that many have been forced to raise fees for *all other* patients while having fees frozen for Medicare patients — cost shifting from one patient to the other in order to cover increases in overhead expenses.

For these so-called "non-participating" physicians, their Medicare recipients, without financial hardship, are denied a fair reimbursement for the fees they have paid their physician. Here again, they will only receive 80 percent (after deductible) of allowable charges in 1982. If this is not a sham on the American public, I don't know what is!

What can you as a physician in South Carolina do? First, contact your Congressional delegation in Washington and request that they attempt to get this unfair action rescinded. AMA officials in Washington say that Senators and Congressmen tell them they are getting practically no calls or letters from physicians on this matter. I do hope this is not true in South Carolina.

Secondly, take the time to explain to your patients what is happening to them. They deserve to know the facts. Next week I will be visiting with editorial staffs of some of the major daily newspapers in South Carolina. I can assure you this will be one of the subjects discussed. It is high time that physicians went public with this and other concerns. We must be our patients' advocates — we must be pro-active in our profession.

Let me know of your concerns.

Sincerely,

A handwritten signature in cursive script that reads "Leonard".

LEONARD W. DOUGLAS, M.D.
President



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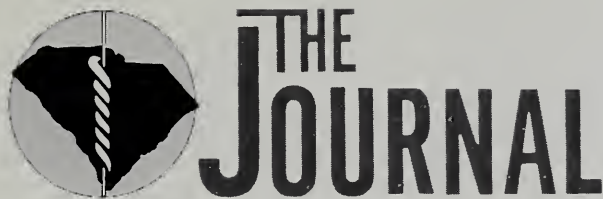
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INTRODUCTION

This issue of the *Journal of the South Carolina Medical Association* is devoted to disorders of the anorectum and lower bowel, a fundamental region too often neglected. To promote the fullest understanding of this topic, the issue includes articles explaining the historical background and societal attitudes towards proctology as well as lead articles on how to diagnose anorectal disease and pain, screening for colorectal cancer, flexible fiberoptic sigmoidoscopy, and the management of hemorrhoidal disease.

The study of anorectal and colonic diseases involves social science as well as medical and surgical sciences. Cultural attitudes towards anorectal diseases have never received from the medical profession the attention they merit. In time, however, every physician finds out how societal attitudes can retard the management of anorectal and colonic disorders.

Throughout history, societal attitudes have supported or retarded progress in the care of certain diseases. Recall the changes in attitudes toward mental diseases, leprosy, and venereal diseases and the progress that was then made in their treat-

ment. These changes occurred because physicians, along with others, campaigned for them. Now is the time for physicians to recognize that cultural attitudes are seriously retarding progress in proctology, and to work together for change.

A related issue that physicians need to address is the formulation of a universally acceptable definition of hemorrhoids. The absence of such a definition has perpetuated misunderstanding in the medical profession and, of course, among every one else. Unless this generation of physicians defines hemorrhoids in acceptable terminology, the next generation will inherit the same confusion.

Some surgeons who specialize in rectal and colonic diseases in South Carolina have contributed articles for this issue. After sketching historical background and reviewing negative cultural attitudes affecting this region they update the scientific knowledge in various areas. And, to provoke discussion they recommend the article on hemorrhoids. We hope you enjoy, discuss and preserve this issue.

LEON BANOV, JR., M.D.

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NEGATIVE CULTURAL ATTITUDES: THEIR RETARDING EFFECT ON PROCTOLOGY

LEON BANOV, JR., M.D.*

This generation of physicians should recognize that inherited cultural attitudes have retarded the management of anorectal and colonic disease. We also need to recognize that cultural attitudes can be changed by physicians, other health professionals, and educators. After we have identified the need to change societal attitudes towards proctology, we must begin to work together to bring about this change.

The study of anorectal and colonic diseases involves social science as well as medical and surgical sciences. Although the effect of negative societal attitudes towards proctology has not received the consideration it should from the medical professional every physician knows well how such attitudes have retarded progress in the management of anorectal and colonic diseases.

Throughout history, societal attitudes have helped or hindered progress in the management of many diseases. History has also recorded that attitude towards diseases can be changed. Recall the attitude toward leprosy. Because it was cited in the Bible, leprosy carried a fearful stigma. Although leprosy was not very contagious, leprosy was feared and lepers were shunned because of the Biblical tradition. In Japan, on the other hand, leprosy never carried a fearful reputation.

Just as stereotypes about leprosy have been changed, attitudes towards mental illnesses have also been changed. In the past, mental patients were thought to be possessed by demons, witches, or hexes, and they were imprisoned, beaten, and brutally treated in numerous ways. Today, although mental illness carries a stigma, changes in attitudes have occurred.

In the past 50 years, attitudes towards venereal diseases have been transformed in large measure because of Dr. Thomas Parran. In the mid 1930's, Dr. Parran, then Surgeon General of the United States Public Health Service, brought syphilis and gonorrhea into the open so that sources and contacts could be identified and treated, thereby

reducing the incidence and spread of these diseases. Aided by other health professionals, Dr. Parran dramatically changed societal attitudes. This is a classic example of how planned change in attitudes benefitted society. Additional examples may be seen in the changes in societal attitudes towards cancer, tuberculosis, and heart disease.

Societal attitudes towards anorectal and colonic diseases have yet to be changed. For generations even scientists have shunned the anorectum. This is especially distressing because the anorectum is a body area easily available for study. Paradoxically, relatively much more scientific knowledge has been accumulated about such difficult areas to examine as the brain, heart, liver, lungs, and other internal organs. This disparity in scientific inquiry is at least partially due to the inherited stigma attached to the anorectum. It has been stated that, "In its collective wisdom, the U. S. Government has spent over 50 billion dollars to study the backside of the moon, an area that caused no one any suffering. But the same government has not spent one cent to study the backsides of its citizens to find out why they suffer from hemorrhoidal disease and what might be done to prevent their painful piles."¹

Current societal attitudes towards anorectal diseases are marked by prudery and embarrassment. The attitude that it is not proper to talk about anorectal diseases has resulted in people knowing relatively little about them. Because of their fear of ridicule, people with anorectal diseases tend to indulge in self-diagnosis and self treatment, thereby delaying professional treatment for serious diseases such as cancer, inflammatory bowel disease and polyps.

Our cultural attitudes about this body area are passed on from one generation to another, mainly from parent to child. Early in life, the child is taught to avoid the term anorectum and to use such terms as "hynie," "tushy," and "tokus." The child is not taught to use the term defecation but such substitutes as "making number two," "go to the potty," and "do duty." Moreover, the child is

* 103 Rutledge Avenue, Charleston, S. C. 29401.

CULTURAL ATTITUDES

not told to say feces but "mess," "stool," and "doo-doo." The child is encouraged to use such euphemisms as "powder room," "lounge," and "rest-room," instead of toilet. When the child becomes an adult, he naturally feels self-conscious about using accurate terminology.

These coy evasions in our vocabulary have promoted humor. Humor comes from pleasure in the indirect expression of forbidden urges. Humor is grand. Life would be dull without it. However, the line separating humor and ridicule is often indistinct. Ridicule, or the fear of ridicule, has tended to keep people from seeking proper medical care when their illness is in an early, curable stage. A related aspect of this problem is that because the anorectal area is hidden from view by clothes, people regard it as "private parts," and their shyness has delayed an incalculable number of people from seeking early medical care for serious illnesses.

This generation of physicians needs to recognize how negative cultural attitudes have re-

tarded progress in the management of anorectal diseases. We should openly spotlight the problem, so that we can work better for its resolution. Although each of us may feel relatively helpless as individuals, together we can work effectively to promote change.

We should discuss the problem with others in our profession. We can discuss it with our patients, friends, and whomever will lend an ear. In this way, we can educate ourselves, our colleagues, other health professionals and the public. We should also consider consultation with social scientists, educators, and people in other disciplines in our efforts to change society's attitudes.

Public opinion can be changed through knowledge and education. Unless we physicians act affirmatively, the next generation will certainly inherit our negative cultural attitudes toward the anorectum and its disorders. □

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HOW TO DIAGNOSE ANORECTAL DISEASE

LAWRENCE H. ERDMAN, M.D.*

Obtaining a detailed history is an important first step in the diagnosis of anorectal disease. The physician should know about the type of bleeding, pain, protrusion, swelling, mucous, itching, bowel habit changes, mass formation, and the duration of these symptoms. Specific questions in this reference will obviate time consuming descriptions by the patient.¹

BLEEDING

The physician should ask whether the bleeding is bright red or plum colored, and try to get an impression about its amount. Is it spotting on tissue paper or coloring the bowel water pink or red? The type of bleeding may suggest the site (see Table).

The first step in examination is inspection and then digital palpation. Anoscopy and proctoscopy follow. Many bleeding anal fissures are not visible externally and can only be seen with an anoscope. The middle-sized Hirschman anoscope is much better to use than is the usual disposable plastic anoscope.

Bleeding hemorrhoids are best evaluated with an anoscope. With the anoscope in the anal canal, ask the patient to bear down. Internal hemorrhoids may then prolapse into the scope. I often ask the patient to sit on the commode and strain down. This procedure will show the true hemorrhoidal picture not obtainable in any other way. Also a true rectal prolapse will not be missed.

The rigid sigmoidoscope is of great value for the aspiration of gross blood in the rectum. When the bleeding is not excessive and no lesions are seen in the rectum, flexible sigmoidoscopy is the next step.

If the bleeding source is still not found, evaluation of the proximal colon and gastro-intestinal tract must be made. It may even require upper gastro-intestinal endoscopy. The radioactively tagged red blood cell study can be very helpful.² It may help point to the level of bleeding when the bleeding is intermittent over a period of several

hours. Mesenteric angiography is helpful only if the bleeding is continuous. If the bleeding is not excessive, colonoscopy, when technically possible, is ideal. Barium enema examination is a last choice.

Sometimes the eating of fresh beets will redden the toilet bowl water causing unnecessary alarm. Fecal occult blood testing will differentiate.

In summary, outpatient or office use of the anoscope, rigid sigmoidoscope and flexible sigmoidoscope will identify the source of rectal bleeding in most cases. If this procedure is followed, fewer barium enemas will be ordered. Do not routinely order a barium enema examination as a first step.

PAIN

The most common cause of rectal pain is an anal fissure. This is often accompanied by spotting of bright red blood, rarely more profuse bleeding. Sixty percent or more of fissures occur in the posterior commissure of the anal canal. The other forty percent or less are in the anterior commissure. A lateral fissure is a rarity. If present, it suggests the possibility of Crohn's disease. A similar type wound with poor healing may follow hemorrhoidectomy or other anal surgery, appearing as a lateral fissure. To examine for fissure, I always use a cotton tipped applicator with five percent Xylocaine ointment in the anal canal as an initial step. This will partially anesthetize the fissure so that the examination can proceed. Some fissures cannot be seen externally without the use of an anoscope, preferably the middle-sized Hirschman anoscope.

The next most common cause of anorectal pain is thrombosis of an external hemorrhoid, obvious on inspection.

Perianal abscess may occasionally resemble a thrombosed external hemorrhoid, but it usually has a more peripheral location with induration and tenderness. More difficult to diagnose is a high intersphincteric abscess located above the dentate line, invisible from the outside and often too tender for digital examination. The differential between this diagnosis and a painful, acute anal fissure may be impossible without anesthesia.

* Proctologic Clinic, 3321 Medical Park Road, Suite 205, Columbia, S. C. 29203.

ANORECTAL DIAGNOSIS

TABLE: CAUSES AND SITES OF RECTAL BLEEDING

<i>Nature of bleeding</i>	<i>Most likely site</i>	<i>Most likely condition</i>
On clothing	Perianum	Rupture of thrombosed external hemorrhoid Prolapsing internal hemorrhoids
On toilet tissue	Perianum or anal canal	Internal hemorrhoids Anal fissure Pruritus ani
In toilet bowl	Anal canal or lower rectum	Internal hemorrhoids, especially prolapsing Ulcerative proctitis Rectal polyp
On stool	Anal canal or rectum	Internal hemorrhoids Anal fissure Rectal polyp Rectal carcinoma
In stool	Sigmoid or higher	Diverticular disease Carcinoma of colon Polyp of colon Arteriovenous malformation Upper GI lesions

Common sites of bleeding (after McLeod J H, *A Method of Proctology*, Harper and Row 1979).

The "fissuroid syndrome" manifested by multiple radially located skin excoriations or abrasions in the perianum, often seen along with pruritus ani, may be extremely painful. This is usually due to excessive scratching and trauma from overzealous cleanliness.

The "levator syndrome" is associated with burning discomfort high in the rectal canal, and will be missed as a diagnosis unless the puborectalis portion of the levator and muscle is palpated carefully.³ Tenderness on its palpation may be so extreme that the patient cries out. Proctoscopy and anoscopy are normal.

More recently electrogalvanic stimulation of the levator muscles, using a transanal probe, has been found very helpful.⁴

Rectal tenesmus, or a feeling of urgency at stool, may be associated with rectal carcinoma, ulcerative proctitis, Crohn's proctitis, and rectal gonorrhea. Proctoscopy is a must to confirm the diagnosis.

Do not miss an anal canal carcinoma by failing to biopsy a lesion. Thickened leukoplakic changes in the anoderm and perianum may require biopsy to rule out intraepithelial carcinoma. Indurated ulceration likewise indicates biopsy. Mass formation in the anal canal may require anesthesia for proper exploration and biopsy to distinguish be-

tween invasive carcinoma and chronic abscess formation.

Digital rectal examination must include a 360° sweep of the distal rectum. A tumor of the lower rectum in the sacrococcygeal hollow may be very difficult to see with a proctoscope. However, careful digital examination may touch the tumor.

SUMMARY

Not all anorectal diagnoses are immediately apparent. In such cases re-examination after an interval of 24 to 48 hours often is of value in some cases with anorectal pain. Use of a proctoscopic table, with the patient kneeling, helps. Some lesions, however, may fall away from the patient in a lateral Sims position or on his or her back. Always remember to feel for rectocele in women and for prostate abnormality in men. □

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HOW TO DIAGNOSE ANORECTAL PAIN

RICHARD ALIA, M.D.*

A diagnosis of anorectal disease often can be made from the description of the pain that the patient experiences. Anorectal pain, which may range from minor itching to intense sharp pain which violently throws the patient out of bed, can suggest a variety of disorders. Description of the pain, duration, character, and rapidity of onset, gives clues to the diagnosis of anorectal disease. A colleague reports that his telephone receptionist, remembering that ninety percent of anorectal pain is caused by anal fissures, acute hemorrhoidal disease, or perianorectal abscesses, correctly diagnoses anorectal pain an astonishingly number of times.

Itching is a form of pain. Usually the itching results from some type of inflammatory process involving the perianal skin. The inflammation of the skin may be due to seepage of stool, or too vigorous rubbing, or mucous from the rectum, or infiltration of the perianal skin by neoplastic disease, or by various forms of chronic dermatitis. However, the most common cause of itching is idiopathic pruritus ani.

Throbbing pain of gradual onset increasing in severity and persisting suggests abscess formation. The patient tells of the onset of a dull aching pain or an irritated area at the anal verge which over the ensuing days becoming more and more painful and taking on a throbbing quality. Associated with this pain is usually a swelling of the affected tissues. However, if the abscess is located quite deep in the post anal space or in the ischiorectal fossa there may be no external swelling. Often the pain becomes quite severe within 24 hours. The patient cannot walk comfortably and sitting is extremely painful. In order to avoid the pain of compression on the abscess, the patient usually sits half on the chair and half off the chair. Often just seeing the patient sitting in the waiting room protecting his perianal abscess from compression will make the diagnosis before the patient even comes into the consultation room.

In contradistinction of this gradual onset of a throbbing pain associated with abscesses, acute

thrombosed hemorrhoids usually are associated with sudden onset of swelling and severe pain at the anus. The onset of pain may be related to either heavy lifting or exertion or straining at a bowel movement. Suddenly the patient feels a minor irritation of pain which within a matter of minutes becomes excruciatingly painful with a large swollen mass at the anus. Over the ensuing days, this pain gradually becomes less severe and by 72 hours is usually starting to resolve. The pain of an abscess, in contrast, gradually becomes increasingly more intense and almost intolerable.

Pain described as cutting or tearing or burning at the anus is usually associated with some break in the lining of the anoderm. This frequently is due to an anal fissure. The pain is felt on bowel movements when the opened tissues become bruised and soiled with fecal content. When the bowel movement occurs, the patient states that there is a feeling as though his bottom is being cut with glass, or that there is a tearing, or that there is a severe burning which lasts for several minutes to hours following the bowel movement. This type of pain with and after bowel movements is characteristic for fissures-in-ano. Often the diagnosis can be made from the patient's symptoms.

Hemorrhoidal disease, on the other hand, does not usually have this type of rhythmic pain sequence. Hemorrhoids most often cause a dull aching pain or a soreness in the anal canal. There may be pain with bowel movement and prolapse. As soon as the bowel movement is over, the pain becomes less intense. The patient does not experience the exquisite type of pain associated with anal fissure. The pain of fissure disease usually decreases as the day progresses and is generally not present on the following morning. When the patient has his next bowel movement the sequence of post defecatory pain begins again. However, hemorrhoidal pain usually gets worse as the day progresses, especially if the patient moves around a lot. As the hemorrhoids protrude more during the course of the day, the patient becomes more uncomfortable. Sometimes the patient has to lie down in order to obtain some relief.

Patients may complain of a feeling of fullness within the rectum. They may describe this feeling

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as though there is a rubber ball within the rectum or a feeling of pressure within the rectum. This type of pain suggests a variety of anorectal conditions, as impactions, or tumors, or foreign bodies in the rectum. When no obvious etiology is found, the physician should think of levator muscle syndrome. This is thought to be due to muscle spasm of the puborectalis muscle. Usually this syndrome can be diagnosed by palpating the puborectalis sling as it passes anterior to the coccyx. Palpation of the levator muscle will cause pain that resembles that of the patient's complaint.

Proctalgia fugax produces a characteristic type pain. Usually the patient feeling well suddenly experiences painful sensation in the rectal area. This pain may last a minute or even hours. Sometimes the pain can be quite severe, and the patient may even collapse to the floor. Much more frequently, this pain awakens the patient at night from a sound sleep. Although the pain eventually subsides, patients resort to a variety of methods to reduce the pain. The person may go to the commode, or sit in a tub of warm or cold water, or apply ice packs or hot water bags, or give themselves an enema or insert a suppository, or eat, or drink, etc. This condition, sometimes termed "rectal migraine," is benign and not associated with any serious anorectal disease. It is usually seen in very nervous, high strung individuals with an irritable bowel syndrome.

In my practice, the most common causes of anal pain in the order of frequency are chronic anal fissure, acute thrombotic or inflamed hemorrhoids, perianorectal or deep space abscess, fistula of the anorectum, levator muscle syndrome, carcinoma of the anal canal, and proctalgia fugax.

SUMMARY

By listening and paying attention to the patient's description of the pain, noting its onset, duration, quality, severity, what aggravates the pain, and what relieves the pain, the physician frequently can strongly suspect the diagnosis even before the examination is carried out. □

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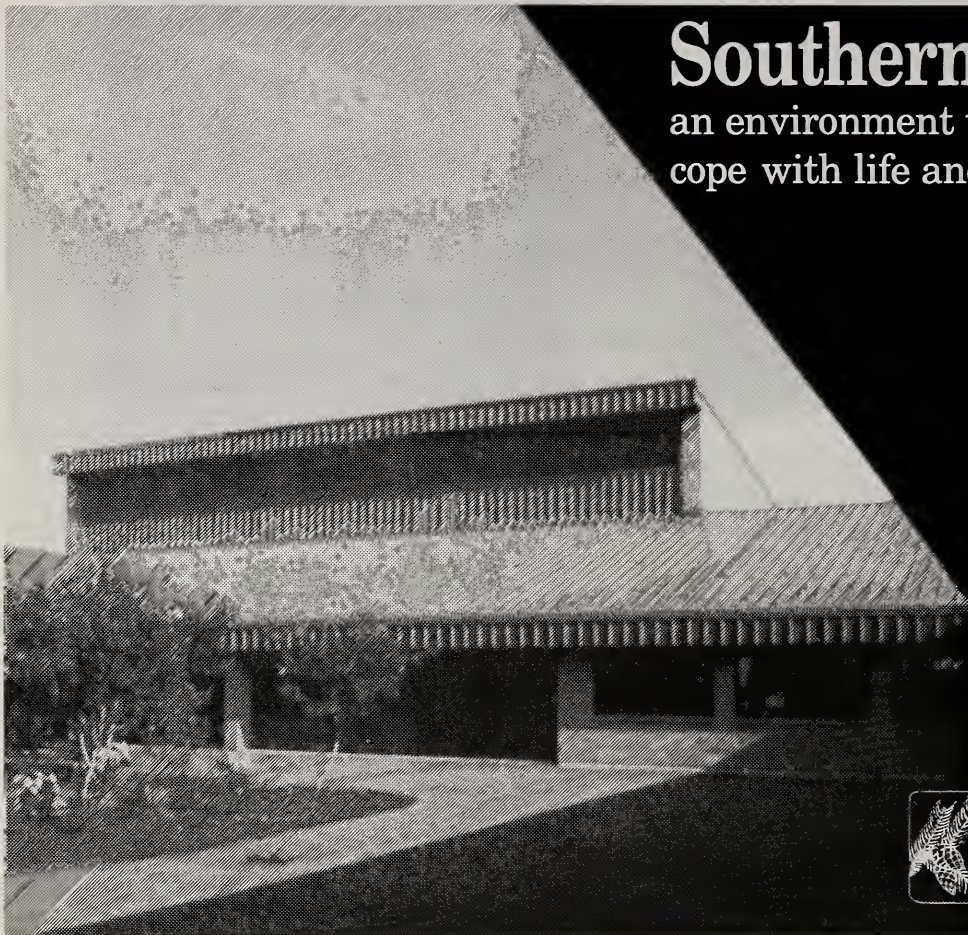
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SCMA

NEWSLETTER

July, 1985

ELECTIONS: STATE BOARD OF MEDICAL EXAMINERS

The SCMA Board of Trustees has been deeply involved with the reorganization of the Board of Medical Examiners since the Board was declared unconstitutional by the State Supreme Court.

The Association worked diligently to insure that the legislative relief to the court's action would be acceptable to all physicians, and the Board of Trustees believes that the SCMA succeeded. The Interim Board of Medical Examiners is now in the process of soliciting nominations and conducting the first election.

The SCMA believes that this first election will be the most important and that it is vital for physicians to participate in this process. The SCMA also feels that continuity on the Board is essential, since many matters pending before the Board prior to the Court's action must be reconsidered.

The SCMA Board of Trustees, at its last meeting, recommended that the current members of the Board be given careful consideration when the votes are cast, and that the continuity of the Board be given heavy weight.

Leonard W. Douglas, M. D., SCMA President, in a recent letter to all South Carolina physicians, stated: "Keep in mind that the current Board members were nominated by organized medicine originally and have fulfilled their duties well. The Court decision was in no way a criticism of the character or competence of the Board."

The Board of Trustees of the South Carolina Medical Association requests the support of the SCMA position in this matter.

SCMA MEMBERSHIP - 1985

In June, the total membership in the South Carolina Medical Association topped the 3,000 mark. For many leaders and others interested in the growth of the association, that was a milestone! Total membership, of course, includes all members - active, affiliate new, honorary, house staff and student.

However, that is only one of two goals set by the Board of Trustees (formerly Council) a year ago. The other goal was to enlist 2,500 active members. At this time, we are close to 96% of that desired figure.

Hampton County, with 100%, and Bamberg County, with 91%, lead the state with the highest percentage of members. Of the larger county medical societies, Spartanburg (86%), Anderson (83%) and Greenville (75%) have all had exceptionally fine membership efforts this year.

1985 still has the potential for a great membership year. We can meet the goal with a little help from our "friends," and everyone reading this Newsletter is a "friend." If you know a physician who is not a member, please ask that individual to become part of the team. Successful membership campaigns have been a factor in maintaining the SCMA dues at the same level for nine years -- let's make 1985 an outstanding year!

NEWS FROM THE AMA ANNUAL MEETING

John C. Hawk, Jr., M. D., SCMA Alternate Delegate to the AMA and a former SCMA President, was re-elected for a third term to the AMA Council on Constitution and Bylaws at the AMA Annual Meeting in Chicago in June. Dr. Hawk received a total of 313 votes out of a possible 368.

The SCMA had excellent representation at the AMA Meeting, including delegates, alternate delegates, officers and staff -- as well as a sizeable number of South Carolina Auxilians.

Harrison L. Rogers, Jr., M. D., a General Surgeon from Atlanta, assumed the Presidency of the AMA, and John J. Coury, Jr., M. D., a Surgeon from Port Huron, Michigan, is President-Elect. Dr. Coury was a distinguished guest at the 1985 SCMA Annual Meeting in Charleston. At a reorganization meeting, the AMA Board of Trustees chose William S. Hotchkiss, M. D., a Thoracic Surgeon from Chesapeake, Virginia, to serve as Board Chairman.

An increase of \$45.00 in AMA dues was approved by delegates. The Board of Trustees said the increase was necessary to continue the Association's representation of the nation's physicians and to expand AMA activities, while maintaining adequate financial reserves.

AMA membership increased in 1984 to 281,400 dues-paying members,

COUNTY SOCIETY VISITATION PROGRAM

Leonard W. Douglas, M. D., SCMA President, continues to welcome invitations for representatives of SCMA officers and staff to visit county society meetings during the upcoming year.

The purpose of such meetings is to share with the medical community throughout the state the new and innovative programs of the SCMA and the concerns which the association is addressing, as well as to hear local concerns and suggestions for future SCMA activities.

Thus far, visits by the President and SCMA staff have been scheduled for the *Marlboro, Greenville, Horry, Darlington, Pickens, Colleton and Cherokee Medical Societies.*

For additional information, contact Donna Houston at SCMA Headquarters, 798-6207.

AMBULATORY CARE SURVEY

For a number of years, the National Center of Health Statistics has conducted a National Ambulatory Medical Care Survey. The statistics gathered during these surveys, while very useful from a national perspective, do not permit an accurate, in-depth analysis of the patterns of private office and clinic physician utilization in South Carolina, and this weakness in the national system can have wide-reaching consequences in a state such as ours. For example, compared to the national average, South Carolina has been consistently low in physicians to population. However, these ratios do not reflect the demand for physician services in our state and planning for our future needs should include demand information.

In an effort to develop more accurate, timely and descriptive statistics about ambulatory patients in South Carolina, the National Center for Health Statistics has assisted the Division of Research and Statistical Services in the development of parameters to participate in a state-level survey.

A random sample of South Carolina physicians is being asked to participate. If you are one who is called upon, please return the postcard indicating your willingness to assist in this survey. If you desire additional information before making any commitment, please contact SCMA Headquarters.

In a letter encouraging physician participation, President Leonard W. Douglas, M. D., states, "Practicing physicians are the only reliable source of information of this type, and for this reason your participation is essential to the success of the survey. If the response to this survey is poor, state and national government entities will be forced to rely on data that we know are not representative of the practice of medicine in South Carolina."

IMPORTANT REMINDER...

...Shortly following the Fourth of July holiday, you should have received a folder outlining an important disability plan from this office. It will only take a few seconds to read and it should prove worthwhile. If you did not receive this mailing, contact the SCMA Office of Information.

NOTICE TO MEDICARE PARTICIPATING PHYSICIANS

Medicare participating physicians who want to accept assignment on a claim by claim basis (i.e., return to a non-participating status) must notify your Medicare Intermediary of your intentions, in writing. Otherwise, your participating agreement signed last year will automatically renew. Although not required, SCMA suggests mailing such notification by certified letter by September 1, 1985, if you wish to discontinue the participating agreement.

AMA DRG MONITORING PROJECT

The AMA, through its DRG Monitoring Project, continues to invite written comments from physicians describing their early experiences with the Prospective Pricing System (PPS).

Information provided by physicians is enabling the AMA to make a broad-based assessment of PPS experiences in various hospitals. During the first five months of the DRG Monitoring Project, the AMA received responses collectively representing the experiences of 6,500 physicians.

The purpose of the project is to permit the AMA to pinpoint shortcomings or benefits of PPS. Prior responses formed the basis of an initial AMA report submitted to both the Prospective Payment Assessment Commission (PPAC) and the Health Care Financing Administration (HCFA). Copies of this report may be obtained by writing AMA's Department of Health Care Resources.

Particular areas of interest to the medical community are the effects of PPS on: quality of care, length of stay, costs of care, admission/discharge policies, utilization review and physician-hospital administrator relations.

Comments should reflect both positive and negative aspects of the program. Letters should be directed to AMA's DRG Monitoring Project, P. O. Box 10947, Chicago, IL 60610.

SCREENING FOR COLORECTAL CANCER

LOUIS F. KNOEPP, JR., M.D.*

It is important that the primary physician understands that the onset of colorectal carcinoma is attendant with quite vague and insidious symptoms. Minor changes in bowel habits and vague abdominal cramping pain are symptoms easily dismissed by the patient. A slight bit of rectal bleeding or straining at the stool is often attributed to hemorrhoids.

Because of this, only 44 percent of colorectal carcinomas are diagnosed in an early stage (without lymph node or distant metastases).¹ Yet if colorectal carcinoma is diagnosed by rigid sigmoidoscopy when asymptomatic, the five year survival rate approaches 90 percent.² The American Cancer Society estimates that with early detection the overall five-year survival rate for colorectal cancer could increase from 44 percent to 75 percent with 40,000 more persons being saved from dying of colorectal cancer each year (Figure 1).³

For screening to be effective, a high risk population must be identified. There are three historical factors — a history of colon cancer, colon polyps, or other cancers. These are important if found in the family history, and are even more important if in the history of the individual being screened. However, the most important risk factor of all is age — age 40 is not only over the hill, but it is the age for the first sigmoidoscopy. With each decade past 40, the incidence of colorectal cancer rises exponentially by repeated doubling (Figure 2).

Screening for colorectal cancer serves several purposes. First, a colorectal cancer may be found in an early curable state as mentioned previously. Second, a polyp may be found. There are at least 20 polyps found for every cancer — many physicians feel that most cancers start as benign polyps. It has been shown that removing rectal polyps in a systematic fashion lessens the incidence of subsequent rectal cancer.⁴ And, last, colorectal screening advertises to the patient the danger of colon and rectal cancer and encourages other persons to undergo screening.

TECHNIQUE FOR SCREENING

Screening should entail taking a personal and family history for cancer and polyps and then doing a digital rectal examination. A digital rectal examination is very easy and acceptable to the patient. It will diagnose about eight percent of colorectal cancers. A hemoccult should be done on the stool and if positive, the patient should have a sigmoidoscopy and an air contrast barium enema. If the hemoccult is negative, the patient merely undergoes either a rigid or flexible sigmoidoscopy. If the sigmoidoscopy is positive for polyps or cancers, then again either an air contrast barium enema or colonoscopy may be done followed by appropriate treatment of the cancer or polyps. If the sigmoidoscopy is negative, then three hemoccults may be done by the patient at home while following the special diet (no vitamin C, no peroxidase containing foods, no anti-inflammatory agents and no rare red meat). If these are negative, repeat the entire sequence in one year and if negative every three to four years. The entire sequence should be started at age 40. The American Cancer Society currently recommends:

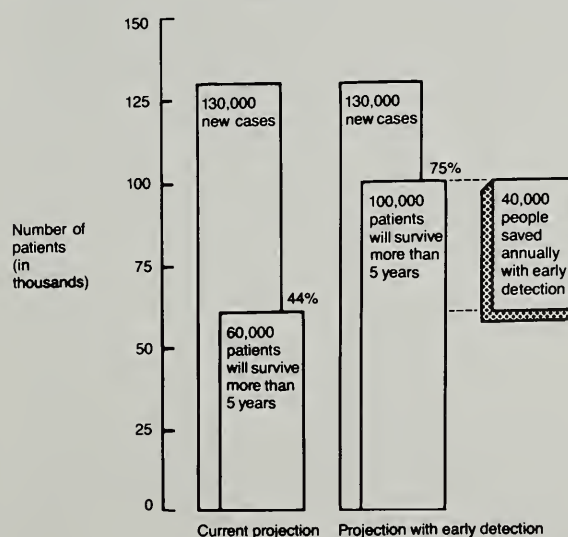


Figure 1: Comparison of 5-year survival rates for colorectal cancer with and without early detection. An additional 40,000 lives can be saved annually with the aid of early detection techniques.

* Wallace Wilson Brailsford Clinic, P.A., P. O. Box 2768, Spartanburg, S. C. 29304.

Source: American Cancer Society

COLORECTAL CANCER

1. A stool blood test every year on everyone over 50.
2. A digital rectal examination every year on everyone over 40.
3. A yearly sigmoidoscopy on everyone over 50 for two years then every three to five years thereafter.⁵

SIGMOIDOSCOPY IN SCREENING

Is a rigid sigmoidoscopy alone a good screen? Yes. About 50 percent of colorectal cancers are seen with rigid sigmoidoscopy. Hertz et al. in 1960 found 58 colorectal cancers by screening 26,000 asymptomatic patients. Eighty percent were Dukes A or B (not involving lymph nodes). The five year survival was 88 percent.² Flexible sigmoidoscopy should be even better than rigid sigmoidoscopy — if one is doing sigmoidoscopy as screening procedure to find polyps or cancer. Marks et al., in a collected series from six physicians, alternated flexible and rigid sigmoidoscopy in 1,012 patients. They found three times as many polyps and two times as many cancers with the long instrument.⁶ The Dukes stage of the cancers was not stated.

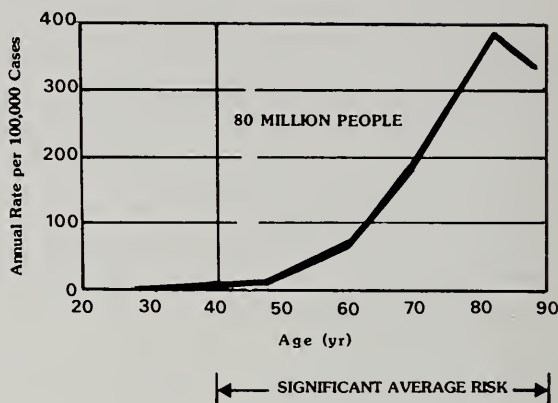
HEMOCCULT SCREENING

Hemoccult screening with three slides is the cheapest and easiest screening method but there are problems. An American Cancer Society screening program was done in 1983 in Chicago.⁷ The public was made aware of the program through four consecutive prime time television news segments. A total of 106,551 patients ordered the test, but only 45,658 (43%) returned the test. A total of 591 screens (1.3%) were positive, and of these 508 (86%) saw a physician. The optimal diagnostic sequence was felt to include proctoscopy, air contrast barium enema, colonoscopy and upper GI series. Only 57 individuals (11.2%) completed this sequence. A repeat stool blood test was done alone in 43 patients (8.5%). The other patients had a variable workup. Twenty-two cancers were found in the 508 patients screened. Fifteen cancers (68% of the cancers) were Dukes A or B. Fifty-three patients (10.4%) had polyps.

Gilbertson in 1980⁸ reported a large scale controlled study of testing for stool occult blood on 48,000 patients age 50 to 80. They were divided into three groups — one group submitted six hemoccults yearly for five years, a second group

INCIDENCE RATE OF COLON CANCER CASES

FIG. 2



Source: American Cancer Society

submitted six hemoccults every other year for five years, and a third group served as controls. Positive individuals (one or more slides) were requested to undergo physical, blood tests, proctosigmoidoscopy, barium enema, colonoscopy and upper gastrointestinal series or gastro-duodenoscopy. Evaluation of 873 positive patients revealed 77 gastrointestinal cancers. This included 16 rectal cancers, 56 colon cancers, three stomach cancers, one pancreatic cancer and one secondary colon cancer. Of the colon cancers 65 percent (49) were Dukes A, 13 percent (10) were Dukes B and 16 percent (12) were Dukes C, and five percent (4) had liver metastases. The median age of the 873 patients was 63 years. Of those younger than 63, five percent had cancer and 26 percent had polyps — of those older than 63 years of age 12 percent had cancer and 35 percent had polyps. Of the 78 percent of cancers located in the colon, barium enema detected 64 percent of the cancers but only 35 percent of the polyps. Thus only 39 percent of colon lesions (168 of 428) were found on barium enema and 61 percent were found on colonoscopy. The barium enema also was noted to detect 90 percent of the Dukes C and D cancers but only 40 percent of the Dukes A and B cancers.

It is important that the individual follows the diet while testing his stool for occult blood. This means no rare meat with visible blood, no anti-inflammatory drugs, no Vitamin C, and no foods high in peroxidase (cauliflower, broccoli, horseradish, turnips, cantelopes, radishes, etc.). The

patient should watch for extraneous sources of stool blood (epistaxis, menses, gums or hemorrhoids). The patient should also be warned that three negative hemoccults do not rule out colon cancer. In some series the instance of three negative hemoccults with known colon cancer was 30 percent.⁹

OTHER SCREENING MODALITIES

Air contrast barium enemas, standard barium enemas and colonoscopic examinations are not ordinarily considered screening tests. They may, however, be done on the truly high risk patient; this includes patients with a past history of colon cancer, a past history of polyps (especially multiple polyps), and those with strong family histories of colon cancer or multiple polyps. An air contrast barium enema is felt by most radiologists to be better for detecting polyps and small cancers than a standard barium enema. Therefore, anyone with a significant risk of polyps or cancer would be better served by having this study. However, an air contrast examination requires a very clean colon, usually meaning a two-day preparation. Colonoscopy may be substituted for the air contrast barium enema on patients with known polyps or on patients with a history of colon cancer. Its advantage is not only in being able to detect smaller polyps than the air contrast barium enema, but also in that lesions may be biopsied and polyps may be removed. Some physicians recommend alternating barium enemas with colonoscopies in following patients with a history of polyps or cancer at intervals of one to three years.

SUMMARY

In summary, colon and rectal cancer is detectable in an early stage if asymptomatic persons are screened. Polyps, which are often pre-malignant, may be even more commonly found and removed, therefore, possibly preventing cancer from developing. The primary physician can determine best who and how to screen. Family and personal risk factors such as a history of polyps or colon cancer are important. Digital rectal examination with a sigmoidoscopy initiated at age 40 and then repeated every three to five years is suggested. Yearly hemoccult screening over 40 is also suggested. □

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FLEXIBLE FIBEROPTIC SIGMOIDOSCOPY

LOUIS F. KNOEPP, JR., M.D.*

The flexible fiberoptic sigmoidoscope (FFS) is essentially a short colonoscope measuring 60 cm (two feet) in length. This compares with the standard full colonoscope which measures about 165 mm (five feet) in length, depending on the manufacturer, and the standard rigid proctosigmoidoscope, which measures 25 cm (10 inches) in length. In experienced hands the flexible sigmoidoscope will reach the descending-sigmoid colon junction in 90 percent of patients, and the splenic flexure in about 50 percent, while the colonoscope will reach the cecum in 90 percent of patients, and the proctosigmoidoscope will reach the lower or distal sigmoid colon at best (Fig. 1).

The flexible sigmoidoscope was designed to be a better, but still easily usable, sigmoidoscope — with the idea that physicians would use it more than the rigid scope and that more patients with rectal and sigmoid colon cancers, and polyps, would be found at an earlier stage. But if the two-foot scope is better, why not use the five-foot colonoscope and try to go the whole route? In theory, at least, this seems a good approach. In practice, there are two main reasons — first, it takes about 45 minutes to do a colonoscopy to the cecum; and second, sedation is usually needed because of the patient's discomfort involved. It also takes a long time for a physician to develop the technical skill to do a colonoscopy even in 45 minutes, and usually this skill is only taught in residency programs. There is some hazard of perforation of the colon, particularly in inexperienced hands.

Flexible fiberoptic sigmoidoscopy is much easier to learn and to do, and the risk of injury to the colon is much less. Preparation of the lower bowel usually involves one or two Fleet enemas, and the examination takes about five minutes and requires no sedation. Short courses in flexible sigmoidoscopy are being offered in abundance, and the price of the instrument and light source is coming down. More and more physicians are using the flexible scope in the place of the rigid

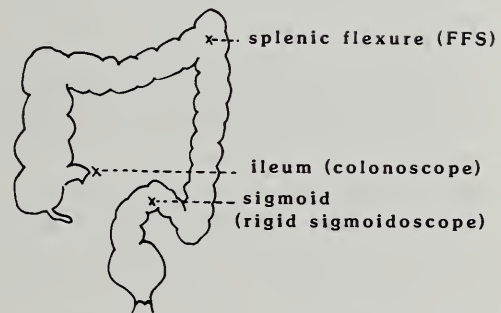


Fig. 1. Distance reached by the 3 main colonic endoscopes.

scope in routine screening of the patient over 45 for polyps and cancer.

MATERIALS AND METHODS

I began using the flexible sigmoidoscope in 1977 as an office substitute for colonoscopy. I had been doing colonoscopy since 1972, and initially I was not certain whether or not the flexible sigmoidoscope was even useful — in other words, every patient needed either a 25 cm proctoscope or a colonoscope. Gradually I began to substitute it for the rigid proctoscope on all patients that I felt might need to have more of the colon seen than the distal 25 cm. This included mainly all patients over 45 and all patients with bleeding, suspected inflammatory bowel disease, or a history of polyps or cancer. Since then I have done 1,400 examinations without any complications other than abdominal cramps or mild vasovagal reaction. I have kept a record of all examinations and I analyzed the results of 1,000 consecutive examinations.

The patients were all outpatients, and although most were over 40 years of age, the age range varied from eight to 83. Preparation usually consisted of two Fleet enemas right before examination, or a standard barium enema preparation (when a barium enema was to follow). The knee chest position was used with the patient on the inverting proctoscope table. Sedation was given rarely, and when given consisted of 50 mgm Vistaril IM. The Olympus 60 cm scope was used most

* Wallace Wilson Brailsford Clinic, P.A., P. O. Box 2768, Spartanburg, S. C. 29304.

commonly, although at times a variety of scopes up to 140 cm in length were used. Examinations were occasionally repeated because of incomplete preparation. Examination distance averaged 52 cm. It is usually difficult to be sure exactly where the tip of the instrument is in the colon.

RESULTS

Results are depicted in Table I. Only the single most important diagnosis was recorded. Diagnoses in descending order of importance were cancer, polyps, colitis, diverticulosis, miscellaneous, and anorectal findings. Miscellaneous diagnoses included post operative anastomosis, strictures, procidentia, melanosis coli, and poor preparation. Anorectal findings included hemorrhoids, fissures, fistulas, prolapse, abscesses, and rectocoeles.

Diverticulosis was present in 153 patients, mostly as an incidental finding. In five patients the diagnosis of diverticulitis could be made, because of either mucosal edema or pus in an area of diverticulosis. Bleeding from an area of diverticulosis was seen in one patient. Flexible sigmoidoscopy was helpful in evaluating strictures found by barium enema, to distinguish carcinoma from diverticular disease or inflammatory bowel disease. Sometimes even with flexible sigmoidoscopy, it was difficult to ascertain the etiology of the stricture with assurance; in these patients, surgical resection was usually done.

Polyps were present in 141 patients. Any lump on the wall of the colon, 2 mm or larger, not obviously a lymphoid follicle, was recorded as a polyp. Of the 141 patients with one or more polyps found on flexible sigmoidoscopy, 76 biopsies were available for review (Table II). The remaining polyps were not biopsied because they were grossly felt to be small hyperplastic polyps. Of the 76 polyps biopsied 34 were hyperplastic, 31 adenomatous, eight villous, and three contained invasive carcinoma. There was gradation in size from the hyperplastic polyps all being under 1 cm to the carcinomas all being over 2 cm.

The location of the 17 carcinomas found in this series of 1,000 flexible sigmoidoscopies is depicted in Figure 2. Eleven were below 20 cm from the dentate line (probably within reach of the standard proctosigmoidoscope), five were above 30 cm, and one was between 20 and 30 cm.

Colitis confirmed by biopsy was found in 56 patients. Chronic ulcerative colitis was found in

TABLE I. Single most important diagnosis made on 1000 FFS examinations

Diagnosis	No.	%
Negative	320	32
Anorectal	179	18
Diverticulosis	153	15
Polyps	141	14
Miscellaneous	134	13
Colitis	56	5½
Cancer	17	1½
	1000	100

TABLE II. Histopathology of 76 polyps biopsied on FFS

Size (MM)	Histopathology				Total
	Hyperplastic	Adenoma	Villous	Cancer	
0-2	20	5	—	—	25
3-5	6	8	—	—	14
6-10	8	11	5	—	24
11-19	—	4	2	—	6
20+	—	3	1	3	7
	34	31	8	3	76

29, ulcerative proctitis (confined to the last 15 cm of the rectum) was seen in nine, nonspecific proctitis in three, Crohn's colitis in three, ischemic colitis in two, and amebiasis in one.

DISCUSSION

Flexible fiberoptic sigmoidoscopy is superior to rigid sigmoidoscopy in ease of patient examination plus depth of penetration with resultant increase in the yield of diagnoses. It is inferior to rigid sigmoidoscopy in the diagnosis of hemorrhoidal disease. It is more difficult to perform than rigid sigmoidoscopy in an outpatient setting. It is also more expensive, and it takes longer for the physician to develop expertise.

The physician performing a colorectal examination would do well to start with a careful history and physical examination and then do a digital rectal. This requires obviously no special equipment. Then an anoscope is a major asset, although it is not as useful as a standard proctosigmoidoscope. It seems to be difficult for many busy generalists to do rigid sigmoidoscopy because of the pain, the necessity of giving enemas, and the need for a suction device to evacuate the rectum.

FLEXIBLE SIGMOIDOSCOPY

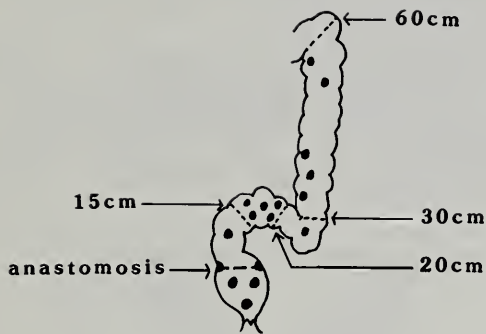


Fig. 2. Location of 17 cancers found in 1000 patients undergoing FFS.

It is easier to first develop expertise with the rigid scope and then move up to the flexible scope. It may be possible to start with the flexible scope in learning, although this approach has not been much investigated and probably results in more hazard from complications, if the physician is not carefully instructed. The standard approach is to first develop skill with the rigid scope.

The flexible sigmoidoscope, or even the colonoscope, is better than the rigid scope for all patients with risk of polyps or cancer.^{1, 2} This includes patients over 45, patients with a previous history of cancer or polyps, and patients with a family history of cancer of the colon or polyps of the colon. A barium enema is also needed — either with or without air contrast depending on the preference of the radiologist. A full colonoscopy is not practical for screening.

Polyps can be removed with a snare through a flexible sigmoidoscope, but the current recommendation is to do total colonoscopy, both to remove the polyps and to search for synchronous (simultaneous) lesions.³ Small polyps and hyperplastic polyps may be biopsied in the office without doing colonoscopy.

Rectal bleeding is better evaluated first by rigid sigmoidoscopy and then barium enema.⁴ Rigid

sigmoidoscopy allows better visualization of the anal canal and hemorrhoidal area, plus the blood clots can be evacuated better through the larger suction tubing available. If no cause for the bleeding is found, a colonoscopy will show a cause not demonstrated by barium enema in about 30 percent of patients. If there is any question of an upper gastrointestinal source, upper GI series, gastroduodenoscopy, and small bowel series are needed.

There is a trend toward the development and use of a more inexpensive flexible sigmoidoscope, either the standard 60 cm length or the more recent 30 cm length.⁵ The advantages of the 30 cm scope may include speed and ease of passage, ease of learning, and fewer complications.

SUMMARY

In summary, flexible sigmoidoscopy can be learned and used by any physician doing a lot of rigid sigmoidoscopies, and its more widespread use is recommended. It is felt that this approach would result in the earlier diagnosis and treatment of both polyps and cancer of the colon. Ultimately this should cause a decrease in the national mortality rate from colon cancer, particularly if most cancers come from polyps. Anyone who already does a lot of rigid sigmoidoscopic examinations, particularly in the patient population over 40, will find it useful. □

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FINANCIAL CHECKUP

MARTIN LEFKOWITZ
Certified Financial Planner
Tax Shelter Co-Ordinator: E.F. Hutton

Vol.5, Issue No. 7

July 1985

PIECEMEAL TAX PLANNING CAN BE HAZARDOUS TO YOUR FINANCIAL HEALTH

The road to chaos is paved with tips on how to reduce your taxes.

"It's not too late to reduce your taxes," blare the headlines of major financial publications every year from January to April and October to December.

"Ten ways to keep more of what you earn," promise countless magazine articles that go on to describe such tax-savings techniques as IRAs, annuities, limited partnerships and municipal bonds.

Taxes, or rather avoiding them, have ballooned into a full blown, American obsession. And while there is no virtue in paying more than your fair share, there is no value in implementing tax reduction strategies without considering them in the context of your total financial picture.

.....There are hundreds of unfortunate stories about people who bought tax-free municipal bonds when taxable investments would have offered them higher after-tax returns. Or then there's the couple who locked themselves into an illiquid tax shelter two years before they were about to retire and require the additional income that their money could have generated in another investment. Or what about the executive who received a lump sum distribution from his firm's profit sharing plan when he changed jobs, established an IRA rollover and then discovered he would have been better off paying the tax and keeping his money liquid enough to provide a down payment for the vacation home he'd always wanted.

PUTTING IT ALL TOGETHER

In the rush to reduce taxes, too many investors fail to realize that tax planning is linked to other considerations in their financial lives. Adding fuel to the fire is the fact that many investors hire lawyers, accountants, and brokers to assist them in different areas. While each may be highly capable of expertise, these professionals are rarely aware of what the others are doing, or, more importantly, of how the plans they suggest might affect their client's other financial concerns.

The answer is not to have one of these professionals take over and explore uncharted waters. Rather, the ideal situation would be to have one knowledgeable, objective person to help you weave together the various threads of your financial tapestry. One who's well versed in how to bring all of your financial concerns-- estate planning, retirement planning, wealth accumulation and saving for specific goals like a child's education -- into a single framework.

A financial planner is such a person. These increasingly popular financial professionals can help you develop a unified program to ensure you reach your objectives in one area without thwarting those in another. And their services are no longer only considered appropriate for the very wealthy.

THE DIFFERENT FACES OF FINANCIAL PLANNING.

Just as no two investors are exactly the same, financial planning services come in different sizes, shapes and forms. Thus, how deep you want to delve is up to you, based on your particular needs and goals. Your net worth and annual income may also come into play in determining a suitable plan.

There is a common thread that ties financial planning services together--that is, the basic steps that lead to the financial plan. They generally go like this:

You meet with your financial planner to discuss your current financial situation. This discussion will probably include a look at your assets and liabilities, cash flow and income tax situation. You may be asked to fill out a questionnaire. In any case, this initial encounter provides the planner with a starting point--the first piece toward solving your financial puzzle.

The next step is to talk with the planner about your future financial aspirations. Maybe you're saving to send your children to college or to secure your own retirement. Or, maybe the sailboat or vacation home you've had your eye on requires more than you've got right now. These goals can all be incorporated into your ultimate financial plan.

From there the planner takes over. He or she will draw up a plan of action hand-tailored to your current situation and aimed at achieving your future objectives -- in other words, one which bridges the gap between steps one and two of the planning process. Sometimes, outside professionals are called in to develop the financial plan, depending on how extensive the plan is. The result is a carefully-planned, realistic set of strategies suited to your financial scenario and goals. That's the ultimate aim of a good financial plan.

That's also where the similarity among financial plans and planners ends. In addition to there being all kinds of professionals (qualified and otherwise) who call themselves financial planners, the financial planning process itself encompasses a broad range of services.

(TO BE CONTINUED NEXT MONTH)

FURTHER INFORMATION

If you would like to receive further information on any of the topics covered in this newsletter, please write to Martin Lefkowitz, CFP, EF Hutton & Company, Inc. 2700 Middleburg Drive, Suite 200, Columbia, SC 29204; or Call (800) 922-1112.

* * * * *

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MANAGEMENT OF HEMORRHOIDAL DISEASE

LEON BANOV, JR., M.D.*

LOUIS F. KNOEPP, JR., M.D.**

LAWRENCE H. ERDMAN, M.D.***

RICHARD T. ALIA, M.D.***

Although not a threat to life, hemorrhoidal disease can make life miserable. To the sufferer, hemorrhoidal disease is no laughing matter.

What are hemorrhoids?

This generation has inherited a potpourri of definitions of "hemorrhoids." Each author gives a different interpretation of the facts in an attempt to define the term. Unfortunately, until we can adequately define hemorrhoids, we cannot say that we adequately treat them.

One dictionary defines hemorrhoid as "a varicose dilation of a vein." If it is a vein, one would expect some patients to pass dark red blood. In actuality, every person with hemorrhoidal bleeding declares passage of "bright red blood."

The blood in hemorrhoids is arterial blood. Thulesius and Gjores determined partial pressures of oxygen (P_{O_2}) and percentages of oxygen saturation in the hemorrhoidal blood.¹ They found the former to average 95.6mm Hg and the latter 97.4 percent, while simultaneous mean values for systemic arterial blood were 98mm Hg and 97 percent respectively. Hence, the proposition that hemorrhoids are dilated veins is incorrect.

Stelzner and his coworkers have stated that the connective tissue architecture of hemorrhoidal vessels resembles that of the corpus cavernous penis.² Also, they note that the blood here is not a metabolism organ, but filling material.

Thomson believed that hemorrhoids are merely displaced and prolapsed cushions, the extrusion resulting from disruption of the supporting tissues.³

To define hemorrhoids for government and industry, an Advisory Panel of the Food and Drug

Administration stated that, "Hemorrhoids are abnormally large or symptomatic conglomerates of blood vessels, supporting tissues, and overlying mucous membrane or skin of the anorectal area."⁴

The patients suffering with the disorder know only that hemorrhoids are piles of trouble.

What causes hemorrhoids?

We don't know.

How are hemorrhoids classified?

Hemorrhoids are classified as external and internal. External hemorrhoids lie below the dentate line (also called the pectinate line, the mucocutaneous junction), and are covered with skin. The lymphatic drainage is to the superficial inguinal nodes.

External hemorrhoids can become symptomatic with inflammation and/or thrombosis. They cause pain because they are innervated by sensory branches of the internal pudendal nerve.

Internal hemorrhoids covered by mucosa lie above the dentate line. They are innervated by branches of the sympathetic and parasympathetic nerves and do not register pain the way external hemorrhoids do. Covered by delicate mucosa they will bleed more easily. The blood may be observed on toilet paper or in the water.

As a guide to management, internal hemorrhoids are categorized into four grades depending primarily upon how far out of the anal canal they prolapse. Grade 1 hemorrhoids occur when there is a tuft of internal hemorrhoidal tissue present, but there is no prolapse from the anal canal. These produce painless bleeding. Grade 2 hemorrhoids not only bleed but also prolapse from the anal canal when the patient strains. They retract after the bowel movement and often the patient does not even know they are prolapsing. They may be demonstrated by watching the patient in the act of straining or identified on anoscopic examination by grasping the hemorrhoid with a forceps

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HEMORRHOIDAL DISEASE

and gently pulling it externally. Grade 3 hemorrhoids are easily identified because they prolapse with a bowel movement and remain out. The patient has to replace them manually. Grade 3 hemorrhoids may be associated with bleeding and perhaps with an aching pain. Grade 4 hemorrhoids remain prolapsed externally all the time and won't stay reduced. There is often a mucoid discharge from the hemorrhoids along with bleeding, and the surface may undergo metaplasia, which is evidence of chronic external exposure.

In each of these four cases the external hemorrhoidal component may be simultaneously involved. The external hemorrhoids may swell and become painful from inflammation and/or thrombosis.

How to manage hemorrhoids.

Every patient should be managed individually. The patient and the hemorrhoids both need to be treated. Generally speaking, all patients over 40 years with any kind of bleeding hemorrhoids should have proctosigmoidoscopy and a barium enema.

a. Acute Hemorrhoidal Disease (External hemorrhoids).

The patient unexpectedly develops a painful swelling in various sizes at the anorectum. The pains persist and may vary in degree. The swelling may remain unchanged, or gradually get larger, or get smaller by a break in epithelium causing an escape of bloody contents. If self-treatment fails, then medical help is sought.

Acute hemorrhoidal disease may manifest itself by inflammation, or thrombosis, or both. In the case of acute hemorrhoidal thrombosis (acute thrombosed hemorrhoids) the lesion is a tender, swollen hemorrhoidal mass of varying size and filled with a thrombus, or more often, with thrombi. If the hemorrhoidal swelling is about one cm. or less and involves relatively little pain, the physician may elect not to remove the clot. If the mass is over one cm. in size and painful, the physician would decide to remove the clot(s) at the office in an outpatient setting. Some helpful tips include using a small 30 gauge needle, 2.25 — 0.5% bupivacaine hydrochloride and epinephrine, or one percent lidocaine with epinephrine. Remember that epinephrine takes at least five minutes to produce a "dry field". Make an elliptical excision to excise the clot and involved ves-

sels. Don't incise and merely enucleate the clot. Leave the wound open. Suggest a return visit in two to four days. Be sure to tell the patient that other clots may develop.

Frequent episodes of acute hemorrhoidal thrombosis in a relatively short time span indicate a need for hemorrhoidectomy.

Sometimes the thrombi are associated with considerable edema of an inflammatory nature. In this case, the physician may elect to postpone for a day or so the excision of the thrombi, or may prescribe antibiotics to accelerate the reduction of the inflammatory edema, and then excise the thrombi.

Sometimes, the painful, acutely inflamed hemorrhoidal swelling of large size is marked by very small (1 or 2mm) thrombi or no palpable thrombi. In this case, antibiotics will speed up recovery. (One of us, LBJr, prescribes Erythromycin 250mg. qid or Tetracycline 250mg. qid for five to seven days). Left alone these inflammatory swellings will subside in time, but antibiotics do accelerate recovery. If varying nostrums are used these will be credited for "shrinking" the hemorrhoidal swelling.

Another form of acute hemorrhoidal disease is marked by prolonged prolapse in addition to thrombosis and inflammatory edema. If the patient is not a good surgical risk, then medical treatment of absolute bed rest, hot compresses and soaks, narcotics or analgesics, stool softeners and sometimes antibiotics or anti-inflammatory drugs can be prescribed.

The prolapse may be reduced by the local injection of lidocaine 1% with epinephrine, or bupivacaine 0.25% with epinephrine added to 300 units of Wydase. With gentle massage, the prolapsed strangulated hemorrhoids will be replaced to their normal position in a few minutes. Then the customary hemorrhoidectomy can be performed. The fears of phlebitis and abscess no longer exist.

b. Chronic Hemorrhoidal Disease.

To manage Grade 1 hemorrhoids, the physician should encourage the patient to change his bowel habits and to take a high fiber diet, adding bulk producers as Konsyl-D, or Metamucil, or Effer-syllium, or Hydrocil, and pushing an increased fluid intake. After changing their bowel and dietary habits, many patients will not have any further hemorrhoidal trouble. If the patient experiences pain in the anal canal and little bleeding, a

short course of treatment with hydrocortisone suppositories may be beneficial. If this does not stop the bleeding, the patient should be considered for sclerotherapy. This treatment consists of the injection of 5% phenol and almond oil, or quinine and urea compound, into the hemorrhoidal complex. This injection is made in the submucosa surrounding the hemorrhoidal tissue about one centimeter above the dentate line near the rectal wall where sensitivity is minimal. Approximately 1 to 2 cc. of the substance is deposited in the submucosa, taking care not to inject it intraarterially or intravenously. If this injection is done in the major quadrants, the patient should have very little discomfort, perhaps complaining of a dull ache or a feeling he has to defecate. This therapy should always be done after the patient has received an enema. After the injection, the patient should be on a bulk laxative and fiber diet. Injection therapy often can stop hemorrhoidal bleeding within a week or two. In two weeks, if necessary, another injection can be given. Injection therapy works very well for Grade 1 hemorrhoids for it causes constriction of the tissues and fibrosis around the capillary beds, a fibrosis resulting from the inflammatory reaction produced by the injected material.

Grade 2 hemorrhoids can be treated medically just as the Grade 1 hemorrhoids are treated. Also, they can be treated by rubber band ligation. This form of therapy is best done in the office as an outpatient treatment with the patient having taken a Fleet enema. Usually one hemorrhoidal group is banded at a time. If the patient seems to tolerate the banding well, multiple hemorrhoids can be done. The internal hemorrhoid is grasped with a forceps and pulled up into the banding instrument and a small "O" black rubber band is placed around the hemorrhoid. Care must be taken to be absolutely sure that the underlying muscle is not pulled up into the band and that the band is placed high above the dentate line where no pain sensors are located. If properly placed, the banding produces very minimal pain; sometimes a nagging, aching sensation or feeling of a need to defecate may be present. Lasting for only 24 hours, this reaction can usually be controlled with warm sitz baths and analgesics. In about five days to a week, the band has completely cut through leaving a small ulcer in the region of the previous hemorrhoids. This ulcer usually spontaneously heals with fixation of the hemorrhoid complex to

the underlying rectal wall and resolution of the patient's symptoms.

Banding may produce some serious complications. Anyone who performs banding must realize that at the time the band necroses through the tissue there can be some bleeding. If the bleeding persists, the patient's return trip to the office or hospital for suture ligation of the bleeding point may be necessary. Occasionally, acute thrombosis of the internal and external hemorrhoid complex will take place with some inflammation. This can be treated with warm soaks and antibiotics. There have been a few cases of severe infection following rubber band ligation reported in the western United States; these seem to be centered around San Francisco where there is a large homosexual population.

Grade 3 hemorrhoids can be treated with banding. Sometimes multiple bands are needed on the same hemorrhoid complex, since it is usually quite large and will not respond to one treatment. Occasionally Grade 3 hemorrhoids are of such a large nature that banding is not satisfactory treatment and hemorrhoidectomy needs to be done. If the external component of the hemorrhoids is quite large with skin tags and considerable external swelling, it is usually best to recommend that the patient have a hemorrhoidectomy rather than to attempt banding.

Grade 4 hemorrhoids almost always require surgery and usually there is a good result from this form of therapy.

Some comments.

When a patient complains of hemorrhoids, a catch-all term, there may be a fissure, fistula, pruritus ani, hypertrophied papillae etc., in addition to hemorrhoids. The physician should be sure he or she is treating only bleeding hemorrhoids and not a colonic polyp or cancer.

There will be cases that can be treated either by hemorrhoidectomies or by conservative measures. Here, the physician should discuss the matter with the patient, giving both pros and cons. One good indication for an operation is that the symptoms of hemorrhoidal disease should be of greater magnitude than the operation. If the symptoms are more severe than hemorrhoidectomy, the patient will consider the operation a success. If the symptoms are relatively less than the pain and inconvenience of the operation, the patient will often feel dissatisfied and blame the operation.

HEMORRHOIDAL DISEASE

Before hemorrhoidectomy, the surgeon or one of his/her staff should discuss in detail the preoperative tests and proceedings, the anesthetic, and the operation and should outline the postoperative course. This briefing will ensure the patient's confidence and will help assure a smooth convalescence. The psychologic preparation of the patient benefits both patient and surgeon.

When the patient leaves the hospital, the surgeon should reassure and instruct the patient. For many years one of us (LBJr) has encouraged the patient to "memorize" printed instructions and reassurances. A copy of these instructions is available from the author.

CONCLUSIONS

The difficulties in treating hemorrhoids are exacerbated by the inexact definitions and uses of the term "hemorrhoids." When hemorrhoids produce symptoms we might best use the term "hemorrhoidal disease."

Since words do not adequately describe pa-

thology and treatment, photography to document and depict hemorrhoidal treatment should be used more often to ensure accurate communication.⁵

The confusion created by the terms "hemorrhoids," "hemorrhoidal tissues," and "hemorrhoidal diseases" should spark physicians to develop a definition of "hemorrhoids" that is acceptable universally, or nearly so, in order that future physicians will not inherit the same problems. □

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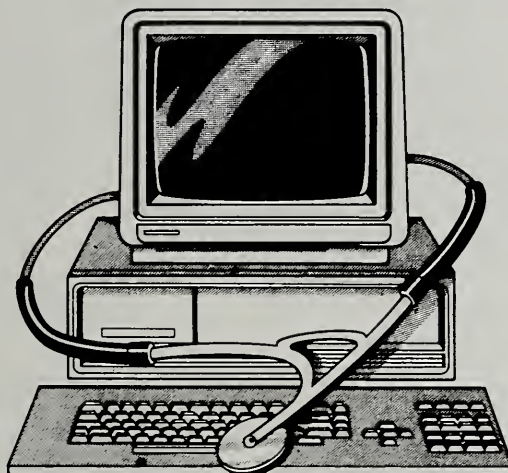
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FECAL IMPACTION

LAWRENCE H. ERDMAN, M.D.*

Fecal impaction is a disturbing development that no physician is anxious to treat. It often requires urgent attention and considerable physical work for both patient and physician. It usually occurs in elderly, inactive or bedridden patients with a long history of constipation. It can also occur in young, healthy individuals, especially in the postoperative state, as after anorectal surgery. Failure of bowel movement over several days results in progressive dehydration of the fecal mass, setting the state for ultimate impaction.

CLINICAL PICTURE

Seepage of loose fecal material or mucous from the anal canal, sometimes called "paradoxical diarrhea," may herald the presence of fecal impaction. Abdominal cramping and a feeling of stool urgency also is present, sometimes suggesting the symptoms of rectal cancer. Digital examination of the rectum confirms the presence of a large, often baseball-sized mass of stool.

MANAGEMENT

Digital break-up of the stool mass must be a first step. It helps to create holes in the mass and fragmentation of it so that irrigating fluids can be more effective. This procedure may have to be repeated over a period of two or three days if the patient is too miserable during the process of digital examination and irrigation. Five percent Xylocaine ointment in the anal canal may allay some pain if fissures are present. I have not had much luck with oil retention enemas. The Fleet's phosphate enema or tapwater enema also sometimes fails. If the fecal mass is still somewhat soft, I have found the following twelve-ounce preparation to be helpful: mineral oil, three ounces; glycerine, three ounces; water, six ounces. The enema should be given with the patient on his left side with bedpan near at hand. In women, transvaginal pressure may help in stool expulsion. In patients who are unable to hold an enema, a good plan is this: procure a sponge rubber ball and have a hole drilled through it of the proper size to fit

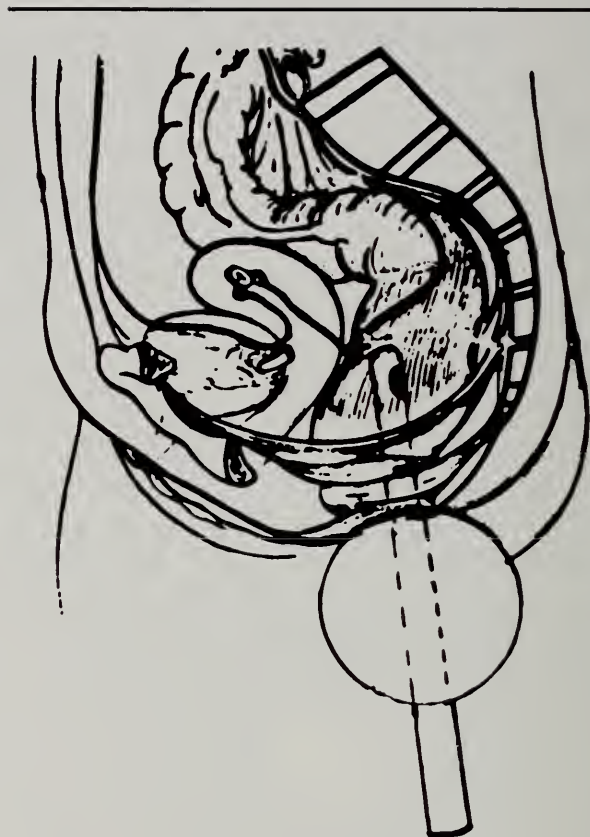


FIGURE 1. Enema for the incontinent. (Modified from Goldberg S et al: *Essentials of Anorectal Surgery*, J.B. Lippincott 1980)

snugly around the enema tube. The enema tube, having transfixed the ball, is inserted rectally and the ball is held firmly against the anus while the enema is given (Fig. 1). (This procedure, of course, requires planning ahead and a readiness for such an event!) The patient can then be moved onto the bedpan. I have used this method with good results. Rarely operative anal dilatation or sphincterotomy under anesthesia is required to remove the unremovable. An heroic dose of castor oil sometimes is necessary as well.

As always, prevention is the best management. A high fluid intake; high fiber diet; psyllium type, water-holding bulk thickeners; lubricants; stool softeners; and occasional use of laxatives are in order. In adults, up to two to three tablespoons of raw unprocessed bran daily will usually supply the needed water-holding fiber. Continued awareness of the developing problem is necessary.

* Proctologic Clinic, 3321 Medical Park Road, Suite 205, Columbia, S. C. 29203.

BARIUM IMPACTION

Barium impaction may follow upper GI X-ray examination for barium enema, but really should not be allowed to occur. To prevent this occurrence, I always order a laxative after either one of these examinations, usually two ounces of Milk of Magnesia. Some radiology departments leave ordering of this laxative to the referring physician. The referring physician, therefore, should order a laxative after barium enema studies, thus protecting the patient and the physician.

CONCLUSION

Anticipate impaction and don't allow it to occur. □

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MEETING ANNOUNCEMENT

*South Carolina/North Carolina
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George Waring, M.D., and
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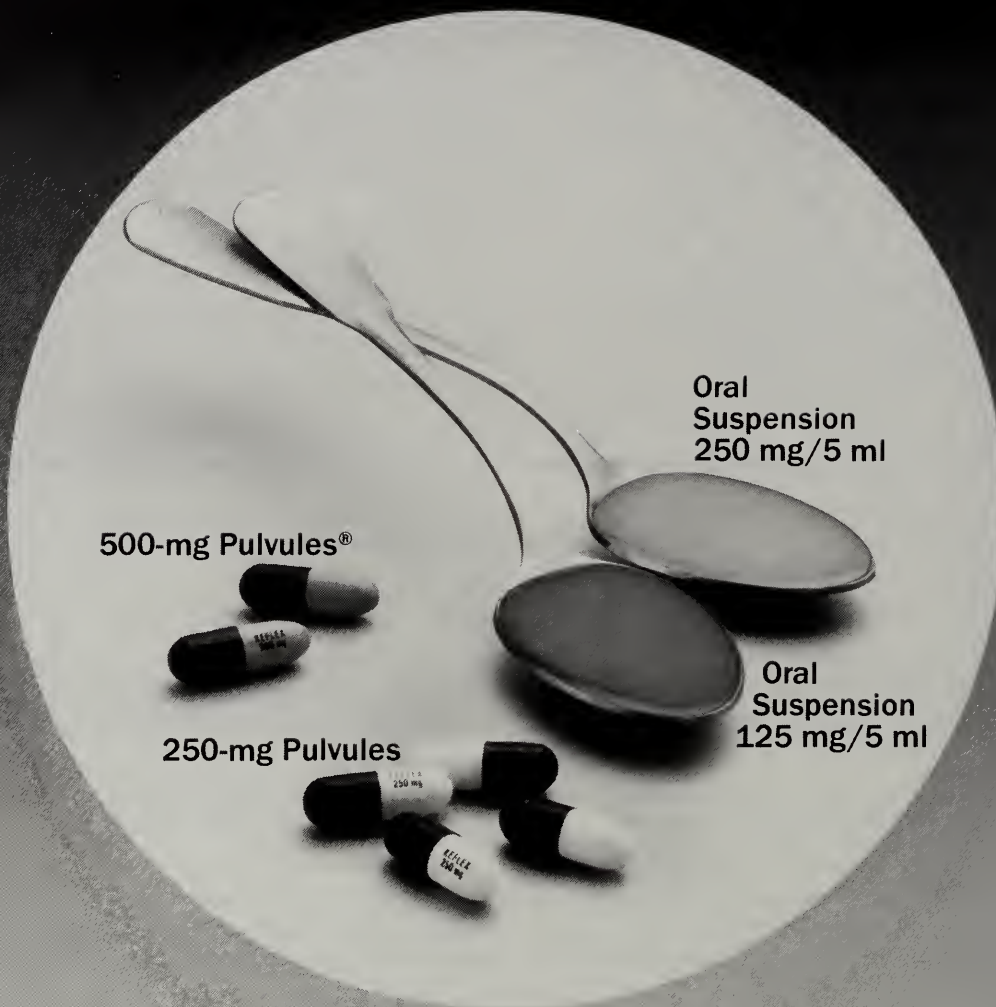
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SUPPOSITORIES: ARE THEY EFFECTIVE?

LEON BANOVA, JR., M.D.*

Since the civilization of Ancient Egypt, the use of rectal suppositories has been documented. And, it is timely to comment on this subject.

Suppositories have been employed for three reasons: (1) to promote defecations, (2) to introduce drugs into the body, and (3) to treat anorectal diseases. The effectiveness of the first two reasons has been well established. The third needs more scientific evidence for proof of effectiveness.

Sanctioned by usage, suppositories are safe in the treatment of anorectal diseases even though their effectiveness continues to be debatable.

Psychologically, suppositories possess considerable placebo effect in the treatment of anorectal disorders. The user feels that something is really being done at the involved site. And this promotes hope — hope of avoiding embarrassment of telling the family and society of what is happening to some area that is very private; hope that the symptoms will go away, thus avoiding a visit to a physician.

Because suppositories are manufactured and sold in such large quantities, many physicians may think they have merit. It should be mentioned that increased frequency of use has been promoted and sustained by good advertising. Advertising that escalates hopes also increases sales. Regardless of remedy employed some anorectal disorders do resolve without any treatment whatsoever. Should after suppository usage the symptoms subside, then the suppository gets the credit. This brings up the question: how does one disprove the effectiveness of suppositories to the consumer who claims to have been helped?

The usage of suppositories in the management of anorectal diseases has been sustained on an anecdotal and testimonial basis, not on sound scientific study.

In the physician's office the patient reports on

failures of suppository treatment, that the suppository did not relieve the symptoms as advertised, and that money was thrown away. Reliance upon prolonged suppository use has caused delay in seeking definitive medical or surgical care. Nearly every physician can recall cases of self-treatment of "hemorrhoids" when in fact polyps, cancer, or inflammatory bowel disease coexisted.

For some anorectal lesions, suppositories with their lubricating, emmollient and protectant qualities are helpful. Presumably the greased surface permits a less painful passage of feces and causes less friction and bleeding.

The "bullet shaped" suppository after insertion can leave the anorectal site and ascend to the rectosigmoid and descending colon. Hence the suppositories should not be used at bedtime.

The suggestion has been advanced that the suppository should be "hour glass" or "collar button" shaped so that the suppository would stay in the anal canal, as in the case for a painful anal fissure. Until such a suppository is manufactured, the physician may suggest the holding of the suppository in the anal canal with the aid of tissue paper. This allows the suppository's ingredients to come in direct contact with the involved anal lesions.

SUMMARY

Suppositories as a dosage form are safe but their effectiveness is variable, depending upon the pathology of the anorectal lesions.

Suppositories should not be removed from the over-the-counter-market place, but increased public education about the treatment of anorectal diseases should be promoted.

More sound research is needed to better prove the effectiveness of suppositories in the treatment of anorectal diseases. □

* 103 Rutledge Avenue, Charleston, S. C. 29401.

Editorial

AND, THE END

Devoted to that area of the body seldom mentioned in polite society, this issue focuses on anorectal disorders which cause a considerable amount of suffering and which are responsible for a large (unknown) number of lost work hours in commerce, industry, agriculture and military.

This issue calls attention to the absence of a satisfactory definition of hemorrhoids, one that is acceptable by all. If we, physicians, cannot accurately define hemorrhoids, how can the public know what hemorrhoids are?

Another word which physicians and laymen use too loosely is "rectum." The anatomy books define the rectum as the segment of the colon between the sigmoid and the anus, a tube of tissues of about 12 to 15 cm. When many laymen use the term "rectum" they usually mean the anal area. As physicians we can promote better understanding by more often using the clinical word "anorectum", and the adjective "anorectal."

As physicians we should learn more about the anorectum so that we may better educate society. Physicians, not the drug industry, should take the leadership in educating people about that organ of continence.

As physicians we should recognize that negative cultural attitudes have retarded progress in the diagnosis and treatment of many colonic and anorectal diseases. We should work together for change in the climate of public opinion.

The historians of the future might ponder this thought. The anal area so readily available for study has been relatively neglected. Yet the heart, brain, lungs, liver, and other internal organs that are less accessible than the anorectum have been studied much more intensively.

In case one wonders about the importance of anorectal disorders, here is what Dr. Oliver Wendell Holmes used to tell his anatomy class about the anal sphincter muscle: "This muscle is very small and its function is menial, but I tell you, young gentlemen, upon its integrity rests the very foundation of society."

Finally, I hope this issue will cause more physicians to make the rediscovery that every patient has a rectum and that any doctor can examine it.

LEON BANOV, JR., M. D.
103 Rutledge Avenue
Charleston, S. C. 29401

LETTERS TO THE EDITOR

To the Editor:

I really enjoyed reading your very thoughtful editorial, "Screening for HTLV-III Antibodies — a Government Blunder." Your astute mixture of scientific fact with ethics and morals is in the highest tradition of the medical profession.

WILLIAM H. HUNTER, M.D.
1 Hunter Court
Clemson, South Carolina 29631

To the Editor:

I'm so very glad that you spoke out in protest against the danger of generating a new hysteria in connection to the AIDS problem. In these days of random panic and public misunderstandings of incomplete facts, we need articulate voices like yours to prevent an emotional and physical calamity. I share your concern about the ruling that blood banks must inform donors of positive serologic tests. I hope that this practice can be stopped or corrected and that more thought is given to the dissemination of information of results which still need a good deal of evaluation and scrutiny.

M. MICHAEL SIGEL, Ph.D.
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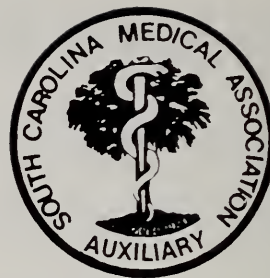
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SOUTH CAROLINA MEDICAL ASSOCIATION AUXILIARY



SCHOLARSHIP AWARDS

This year the SCMA Auxiliary Scholarship Committee was faced with a "wonderful dilemma". Eight worthy students with exceptionally fine credentials had been referred by the state's two medical schools for scholarship consideration. How could they choose only four from among these gifted students?

Dr. Susanne Black, a member of the Auxiliary Scholarship Committee, proposed a possible solution. As a physician member of the S. C. Institute for Medical Education and Research, (SCIMER) an SCMA subsidiary, she asked Nellie Claire Brown to join her requesting SCIMER funding for the additional four scholarships.

The request was granted, and the following eight students will each receive a scholarship of \$800.

MUSC

JOHN P. DAVIS

John is the son of John P. and Joyce A. Davis, Sr. of Newberry, S. C. He is a rising second year student in the College of Medicine at the Medical University of South Carolina where he is academically ranked in the upper one-third of his class. Mr. Davis is a graduate of the College of Charleston. While attending the College of Charleston he was the night manager for the Student Union and the recipient of the Exchange Club Scholarship and the Russell Wragg Scholarship. GPR 3.5



KATHY L. SIEGFRIED

Kathy is the daughter of Henry J. and Ann M. Siegfried of Columbia, S. C. She is a rising second year student in the College of Medicine at the Medical University of South Carolina where she is academically ranked in the upper one-third of her class. Kathy is a graduate of the University of South Carolina and has been selected as a Rich Scholar at the Medical University of South Carolina for the 1985-86 academic year. This award is based on academic achievement and financial need. GPR 3.62

MICHAEL HIGHTOWER

Mike is the son of Franklin D. and Martha S. Hightower of West Union, S. C. He is a graduate of the University of North Carolina at Chapel Hill and Duke School of Divinity. He is married and has two children. Mike is a rising senior in the College of Medicine at the Medical University of South Carolina where he is a Rich Scholar and was awarded the Dobson Scholarship for his work on a project with the World Health Organization, the Veterans Administration Hospital and the Medical University of South Carolina on a new mechanism in e. coli diarrhea. GPR 3.15



USC SCHOOL OF MEDICINE

JAMES REIMAN

James Reiman from Greer, South Carolina, is a rising fourth year student at the University of South Carolina School of Medicine. He is a graduate of Wake Forest University where he majored in Biology, and served on the Student Judicial Board. While in medical school, he has served on several student services committees. GPR 3.712



WILLIAM GLENN BRADHAM

Glenn is the son of William C. and Ruth M. Bradham, Jr. of Florence, S. C. He is a rising junior student in the College of Medicine of the Medical University of South Carolina. Glenn is currently chairman of the Advisory Board for the S. C. Health Coalition, Co-Director of Public Relations — Superhealth 2000, class representative to the Introduction to Clinical Medicine Steering Committee and a student advisor for four freshman medical students. He holds a bachelors degree from Wofford College and a masters degree from Francis Marion College. GPR 3.0

PAMELA E. NORMAN

Daughter of Mr. and Mrs. William T. Norman, Jr. of Greenwood, Pamela received her B.S. Degree in biology in 1982 from USC, *Summa Cum Laude*, with honors from South Carolina College — USC's honors program. She is a student member of the AMA, a member of the USC Medical Student Association, and Phi Beta Kappa. Recently she was employed as a laboratory technician in the Department of Physiology and is currently a senior medical student with special interest in internal medicine. Pam also received an Auxiliary scholarship last year. GPR 3.813



TRACY ABNER

Tracy Abner is from Charleston, South Carolina. Her undergraduate work was done at Furman University where she earned a B.S. in Chemistry. She is a rising third year student at the University of South Carolina School of Medicine. This past year, she served as Treasurer of the Medical Student Association. She will serve as Vice President of her class this coming year. Her personal interests include jogging, baking, and cross stitching. She is married to Brett Abner, a 1985 graduate of the University of South Carolina Law School. GPR 3.725

CATHERINE MAUREEN LONGTIN

Catherine Maureen Longtin, daughter of Mr. and Mrs. Bruce Longtin of North Augusta, is a rising junior at the University of South Carolina School of Medicine. She received her A.S. from USC-Salkehatchie in Allendale and her B.S. in Chemistry from USC-Columbia. As a student at Salkehatchie, she received the Student of the Year Award, Chemistry Student of the Year Award, and Biology Student of the Year Award. She graduated *Summa Cum Laude* from USC-Columbia. GPR 3.983



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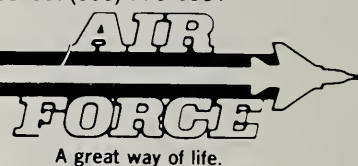
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President's Page



TORT REFORM — A MUST IN SOUTH CAROLINA

Tort reform must be meaningful and it must be effective. Some state medical leaders say that it has helped little in their state. Others say that it has been helpful.

In recent discussions with physicians in Chicago at the AMA Annual Meeting, we learned that many physicians were leaving states such as Massachusetts and New York because of the high malpractice premiums. Many competent physicians are being driven out of high risk specialties such as obstetrics and neurosurgery because of the escalating cost of professional liability insurance.

Many physicians practice defensive medicine to protect against lawsuits, thus driving health care costs even higher. United States physicians pay two billion dollars annually in professional insurance premiums and the costs are passed on to our patients. One in every five physicians today can expect a claim to be filed against him or her.

We have established good risk management programs in the state and we must continue to expand these. Now we must go to the public — to educate the public and the patients we serve about the professional liability problems we (and they) face — and subsequently to the legislature to seek relief. We must build a coalition with business, industry and other professionals to become involved in our tort reform proposals.

Malpractice premiums are escalating because of the number of suits filed and exorbitant awards by juries. It is our belief that where there has been harm to a patient through negligence, there should be just compensation, but in South Carolina 80 percent of the cases filed are lost or dismissed because of lack of merit. Why such a high percentage? Because many attorneys do not adequately investigate their cases and there is no cost to the client if he loses.

I have just reviewed a case brought against a physician in South Carolina — the most frivolous I have ever seen — and the attorneys for the plaintiff dropped the case “on the court house steps” out of embarrassment, but not before they had caused untold grief, frustration and expense for the accused physician. That physician has adequate grounds for a suit against the attorneys, and I assume he will do just that.

The AMA has a draft bill to assist states in getting tort reform through legislatures. In essence, the bill provides federal incentive grants to assist in developing state liability reforms. Funds for the grants accrue from savings derived by the federal government in enactment of these reforms.

Five major reforms in the proposed AMA bill are (1) periodic payments for future damage over one hundred thousand dollars; (2) elimination of the collateral source rule; (3) a cap on non-economic damages; (4) restriction of contingency fees of attorneys; and (5) peer review discipline and risk management.

Obviously, tort reform is a multi-faceted problem and will require a “many-pronged” attack. The SCMA is committed to a meaningful resolution to this crisis. This will most probably be our biggest legislative effort for this year and/or years to come. Your Professional Liability Committee is presently working on a seven-point draft proposal to take to the legislature. The task will not be easy. Many of you will be called upon to assist; please be available. I will keep you informed.

Sincerely,

A handwritten signature in cursive script that reads "Leonard".

LEONARD W. DOUGLAS, M.D.
President



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be made available by the publisher.



LYME DISEASE: A CASE REPORT FROM SOUTH CAROLINA*

ROSLYN D. TAYLOR, M.D.**

MICHAEL PAUL HARRIS, M.D.

In 1975, Steere, et al.¹ investigated a cluster of summertime illness with rash and arthritis which had initially been diagnosed as Juvenile Rheumatoid Arthritis. The original cases occurred in Lyme, Conn. and three surrounding townships. In 1976, a tick vector was postulated for this disease as a result of epidemiologic studies.^{2, 3} In 1982, a spirochete was isolated from the *Ixodes dammini* tick and some of the skin lesions of patients with the disease.⁴ Subsequently the spirochete has been identified as *Borrelia burgdorferi*.⁵ The organism has since been isolated from *Ixodes pacificus* in the west and *Amblyomma americanum* in the northeast.⁶ The range of *Amblyomma americanum* is extensive outside the known endemic region for Lyme disease. Most cases of the disease occur in Connecticut, New York, New Jersey, Rhode Island, Wisconsin, Minnesota, and Massachusetts. Individual cases have been reported in Delaware, Maryland, Utah, California, Nevada, Arkansas, Georgia, and Oregon.⁶ According to Dr. Arthur DiSalvo (personal communication) of the Laboratory Division of South Carolina's Department of Health and Environmental Control, the case described in this report is the first confirmed case in South Carolina.

CASE REPORT

The patient is a nine-year-old black male who

was in good health until July 3, 1984. At that time he had sudden onset of dysuria and hematuria. Cultures of the urine and urethra were negative and the episode spontaneously resolved in about two weeks. Several days after the hematuria cleared, a lesion appeared on his trunk described by his mother as red and raised with central clearing. Rapidly other lesions appeared on the trunk and were thought to be urticaria. The rash seemed to respond well to epinephrine. Several days after the appearance of the rash the patient began to complain of pain in left wrist, left shoulder and right knee. He also began to have temperature spikes to 39.4°C and 40°C at home. His only other symptoms were headache and myalgias associated with the elevated temperature. The fever and joint pains were not responsive to aspirin and he was admitted to the Family Practice Service at Richland Memorial Hospital, Columbia, SC on August 3, 1984. He was on no medications at the time of his admission other than aspirin.

Pertinent findings during the admission were an intermittent, erythematous truncal rash, intermittent swelling of the right knee, and an intermittent low grade temperature with elevations to 38°C. Hgb was 11.9, WBC 9,300 with a normal differential (platelets were 580,000). An ASO titer was positive at 1:250. Throat culture was negative for streptococcus. Urinalysis was normal. Sedimentation rate (Westergren) was 79mm/hr. The ANA was positive at 1:40 in a speckled pattern and the Sickledex was negative. X-ray of his right knee was negative. An ophthalmology consult failed to find evidence of iritis which is associated

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** Address correspondence to Dr. Taylor at the Department of Family Medicine, Richland Memorial Hospital, Columbia, S. C. 29203.

with pauciarticular Juvenile Rheumatoid Arthritis. He seemed to respond at least temporarily to ASA and was discharged with a presumed diagnosis of Juvenile Rheumatoid Arthritis.

After discharge the symptoms continued with polyarthralgias, an evanescent rash and occasional temperature spikes. A return visit one week after discharge revealed no appreciable change in signs or symptoms. Sedimentation rate was 65mm/hr and CBC was essentially unchanged. He admitted to poor compliance with aspirin therapy. At the same time blood was drawn to send to the Center for Disease Control (CDC) for an indirect immunofluorescent antibody (IFA) test to the spirochete, *Borrelia burgdorferi*. On Sept. 6, 1984, the test results were reported as positive with a titer of 1:256 which is interpreted by the CDC as diagnostic. On a return visit on 9/20/84 the patient had no rash, minimal joint symptoms, a sed rate 9, a negative VDRL and a normal CBC. The literature suggests that only *early* treatment of the skin lesion, (Erythema Chronicum Migrans) and arthritis with tetracycline or penicillin shortens the course of the disease and lessens recurrences.⁷ We, however, elected to treat this young man with penicillin V potassium 250mg four times a day for two weeks to decrease his morbidity and school absences if possible. Nine months after treatment he continues to do well. Only in April, 1985 was treatment of Lyme arthritis shown to be effective with high dose parenteral penicillin.⁸

DISCUSSION

The results of a study of the distribution of Rocky Mountain Spotted Fever positive ticks in South Carolina yielded an approximate quantification of the genus and species of ticks most often found on man in the state of South Carolina.⁹ *Dermacentor variabilis* was found 98 percent of the time in the Piedmont. The distribution in the coastal plain was 62 percent *Dermacentor variabilis* and 38 percent *Amblyomma americanum*. A few *Ixodes scapularis* were found; 15,700 specimens collected. In New Jersey 22 percent of the nymphs and 11 percent of the adult males of 44 specimens of *Amblyomma americanum* were positive for the spirochete, *Borrelia burgdorferi*.¹⁰ Because of the wide distribution of *Amblyomma americanum* there is a potential reservoir for Lyme Disease in areas where it has not been reported previously. Perhaps there are

many other unrecognized and untreated cases of Lyme disease in these areas that were not considered at one time to have the proper vector. Since a serological test for Lyme Disease is now available through the Center for Disease Control, it would be of value epidemiologically and therapeutically to send sera to the DHEC Bureau of Laboratories from all patients with a rash suggestive of Erythema Chronicum Migrans and atypical arthritic, neurologic or cardiac symptoms. It is obvious from the wide distribution of individual cases that several types of ticks serve as vectors of the spirochete.⁶ Wider dissemination of information about this disease and the availability of a specific serological test would also make case finding more efficient.

SUMMARY

A nine-year-old black male with a rash and arthritis is described. Serologic studies indicated this disease to be Lyme Disease. This was the first serologically confirmed case in South Carolina. Studies done in the state confirm the presence of one of the tick vectors for Lyme Disease. □

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SUPPURATIVE HAND INFECTIONS IN CHILDREN*

BRENT V. STROMBERG, M.D.**

It is well-accepted that hand infections can be seriously disabling. Numerous authors have outlined the standard treatment of hand infections of rest, elevation, warm compresses, and drainage when appropriate.¹⁻⁴ Most series describing appropriate treatment, etiology, and outcome have dealt with adult populations.¹⁻⁵ To determine parameters of etiology, presentation, and treatment in the pediatric age group, the following study was undertaken.

METHODS

All patients seen at the associated hospitals of the Medical University of South Carolina from January, 1978 through December, 1982 who had hand infections deemed serious enough to require hospital admission were evaluated. Outpatients were excluded to ensure the availability of consistent data and assurance of compliance with treatment. Also excluded were patients with cellulitis only and those for which culture and sensitivity data were incomplete. There were 101 patients treated during this period. Fifteen were below 16 years of age. Division of the group into those patients over 16 (86 patients) and those patients under 16 (15 patients) and comparison of the data of each of these groups form the basis of this study. Presenting data of age, sex, temperature, pulse, white blood cell count and differential were recorded. Culture and sensitivity data and outcomes were also evaluated.

RESULTS

Analysis of presenting data is relatively unremarkable. Except for the obvious difference in ages and an increase in pulse rate, there is no difference in patient profiles of the two groups (Table I). It is important to note that presenting data are not significantly different enough from

normal values to be diagnostic.

Presenting cultures were also evaluated. All patients evaluated had aerobic and anaerobic cultures. Most had fungal cultures and some had mycobacterial cultures. Comparison of the culture data of the pediatric group and the adult comparison group shows several interesting and therapeutically significant differences (Table II).

TABLE I
Presenting Patient Profiles
(mean)

	<i>Pediatric Group (n=15)</i>	<i>Adult Group (n=86)</i>
Age	7.1	42.1
Sex (male: female)	9:6	58:28
Temperature	100.0	99.4
Pulse	112.8	90.3
W.B.C.	10,850	10,000
Neutrophils (%)	65	66

TABLE II
Culture Data
(percent of total cultures)

	<i>Pediatric Group</i>	<i>Adult Group</i>
Pure <i>Staphylococcus aureus</i>	27	34
Mixed Infections containing <i>Staphylococcus</i>	53	35
Pure gram positive infection	40	55
Mixed gram positive and gram negative infection	47	34
Pure gram negative infection	13	7
Anaerobic infection	27	17
Mycobacterial infection	0	2
Fungal infection	0	3

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Hand infections in the pediatric group have less pure staphylococcal infectious (27% vs 34%), less pure gram positive infectious (40% vs 34%), more pure gram negative infectious (13% vs 7%), and more anaerobic infectious (27% vs 17%). No mycobacterial or fungal infections were seen in this pediatric group (Table II).

Significantly, there were 29 bacteria recovered in the pediatric group (1.9 per patient) and 163 in the adult group (1.8 per patient). Thus, the number of bacteria per infection is similar.

Antibiotic susceptibility of an organism is helpful in determining the antibiotic of choice. Comparison with similar infections in adults is shown in Table III. Bacterial sensitivities to antibiotics were routinely better in the pediatric group.

The outcome of the aggressively treated hand infection was usually favorable. One indication of response is the length of hospital stay. Pediatric patients with hand infections stayed an average of 8.4 days as compared with 10.2 days for adults.

DISCUSSION

Soft tissue infections of the hand can be a significant problem at all age groups.¹⁻⁵ The serious nature and potentially devastating functional results have prompted the use of aggressive therapy. Rest, elevation, warm compresses and drainage when appropriate have been the cornerstones of therapy. Early use of antibiotics has also become important.¹⁻⁵

It has been assumed that similar principles apply to infections in children. No comparative studies have been heretofore available. The current study verifies the application of basic principles to include this group as well as to point out several interesting and therapeutically important differences.

The clinical presenting parameters of temperature, pulse, white blood cell counts, differential counts, and prodrome, although occasionally abnormal, are not consistently abnormal enough to be clinically diagnostic (Table I). The diagnosis must rest heavily on physical examination. The elements of pain, swelling and redness are almost invariably present.

Significant information can be found by evaluating bacteriologic data. Early studies of infections of the hand showed the organism to be almost exclusively *Staphylococcus Aureus*.^{6, 7, 8} These authors noted the dramatic effect of penicillin on hand infections. That this would change

TABLE III
Antibiotic Susceptibility
(percent of total bacteria susceptible)

	Pediatric Group	Adult Group
Penicillin	38	20
Ampicillin	41	27
Erythromycin	69	61
Cephalosporins	93	80
Tetracycline	90	71
Methicillin	86	68
Clindamycin	86	76
Chloramphenicol	86	89

through the years has not been unexpected. Numerous recent series have demonstrated a decrease in penicillin sensitivity.^{2, 3, 4, 5} The mechanism for a change in bacterial sensitivity to an antibiotic has been reviewed by Finland.⁹

The effect of this bacteriological evolution has not been available in the pediatric group. The choice of hand infections is fortunate. A precise anatomical area with rigid bacteriologic criteria can be expected to give more meaningful data than the inclusion of larger numbers of more divergent types of infection. Therefore, although the total number of patients in this group is relatively small, the strict criteria for entrance into the study group makes the data significant.

Culture data show significant deviation from the historic *Staphylococcus aureus* predominance. Only one in four patients had a pure *Staphylococcus aureus* culture (27%). However, a full one-half (53%) had *Staphylococcus Aureus* as one component. This is in contrast to the one-third (35%) in comparative adult populations. Significantly, one-half of patients (47%) had mixed gram positive and gram negative infections and thirteen percent had pure gram negative infections. This is less than the 34% and 7% respectively in adult populations. Twenty-seven percent of pediatric patients had anaerobes recovered. (Table II). Even though not all of these differences are statistically significant, the trend is consistent.

Although there is no generally accepted reason for this, the difference in flora in the pediatric age group is undoubtedly multifactorial. It may include a slightly different environment, hygiene, and exposure patterns.

Despite the generally more complex nature of infection in the pediatric group, the sensitivity data are more favorable with increased sensitivity

to most antibiotics throughout. (Table III).

Although penicillin and ampicillin remain poor choices in the treatment of hand infections, there is a notable improvement in their coverage in the pediatric group. A statistical improvement in sensitivities to penicillin, ampicillin, tetracycline, and clindamycin is noted as compared to adult suppurative hand infections. Because of the bacteriostatic nature of tetracycline and erythromycin, their usage should be warranted by other culture or allergy reasons. Likewise, chloramphenicol side-effects limits its use. However, the cephalosporins, the penicillinase-resistant antibiotics (methicillin), and clindamycin remain reasonably good choices overall. Choice among these may best rest with regional variations in sensitivity data within one's own hospital.

Generally speaking, the aggressively treated hand infections in the child resolve rapidly. Average hospital stay of 8.4 days is significantly better than the adult 10.2 days in spite of the more complex flora. Thus treated with appropriate rest, elevations, compresses, drainage, and antibiotics in a well-controlled hospital environment a favorable outcome is usual.

SUMMARY

Hand infections in children can offer a significant therapeutic challenge to the physician. Although the usual surgical principles of treatment of rest, elevation, compresses and drainage when appropriate apply to children as well as to those in older age groups, some differences exist in presentation, bacteriological data, and results. In fifteen pediatric patients with suppurative hand infections significant enough to require hospitalization, presenting data (temperature, pulse, W.B.C. counts, differential counts) were not elevated significantly enough to be helpful. Culture data show there to be less pure staphylococcal (27%) and pure gram positive (40%) infections than in the adult groups (34% and 55% respectively). However, there was an increase in mixed gram positive and gram negative infections (47% vs 34%), pure gram negative infections (13% vs 7%), and anaerobic infections (27% vs 17%) as compared to adult populations. Analysis of antibiotics susceptibilities shows some interesting data. As compared to an adult hand infection reference group, bacteria in pediatric hand infections are more susceptible to commonly used antibiotics. Hospital stay tends to be slightly shorter in children (8.4 vs 10.2 days). □

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MEETING ANNOUNCEMENT

*South Carolina/North Carolina
Societies of Ophthalmology, 1985
Annual Scientific Session*

Faculty: J. Lawton Smith, M.D.,
George Waring, M.D., and
Joseph Flanagan, M.D.

Meeting Site: The Hyatt on Hilton
Head Island, South Carolina

Meeting Dates: Thursday, October
24 - Saturday, October 26, 1985

Credit: AMA Category I, 6 Hours

*For More Information Contact:
B. J. Blanks, S. C. Society of
Ophthalmology, P. O. Box 11188,
Columbia, South Carolina 29211,
(803) 798-6207.*

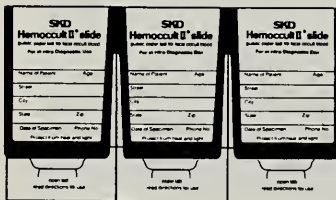
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SCMA

NEWSLETTER

August, 1985

IMPAIRED PHYSICIAN ACTIVITIES

The SCMA Committee on Alcohol, Drug Abuse and Impaired Physicians has received extensive favorable coverage in the July 11 edition of the *Charleston Evening Post*.

Douglas F. Crane, M. D., Chairman of the Committee, described the committee's activities in an interview with the *Post* Reporter. He noted that currently about 35 South Carolina physicians are under contract with the committee for treatment.

If you know of a physician with a possible impairment, contact Dr. Crane at 559-2461, or call the SCMA Headquarters, 798-6207 (or after 5:00 p.m., 798-6979, to leave a recorded message).

Meantime, in its ongoing efforts to guide medical societies in their expanding programs to identify and rehabilitate impaired physicians, the American Medical Association is sponsoring two forthcoming meetings.

The first of these is a *Conference on Stress, Impairment and the Resident*, to be held October 24-28 at the Harrison Conference Center in Lake Bluff, Illinois, a northern Chicago suburb. This program will be jointly sponsored by the AMA's Human Behavior Program, the AMA Resident Physicians Section and the University of Illinois-Chicago.

The other upcoming meeting is AMA's 7th Annual Conference on the Impaired Physician: "*Reaching Out to Physicians, Their Families, Allied Professions.*" It will be held April 10-13, 1986 at the Hilton Hotel and Towers in Chicago. Portions of this program will be co-sponsored by the American Nurses Association, the American Pharmaceutical Association, the American Veterinary Medical Association and the American Dental Association.

For registration and other information regarding either conference, direct all inquiries to Janice Roberson, program coordinator for AMA's program on Impaired Physicians, AMA Behavior Program (312) 645-5079.

Another impaired physician program development of interest is that the AMA's Department of State Legislation has developed draft state legislation for an Impaired Physician Treatment Act which has been approved by AMA's Board of Trustees. This draft legislation is designed to strengthen medical society impaired physician programs.

MEETING DATES OF IMPORTANCE

- SCMA ANNUAL MEETING -

The SCMA Committee to Plan State Meetings has set the following meeting dates, approved by the Board of Trustees, for SCMA's Annual Meetings through 1990:

1986	April 22 - April 27	Sheraton Charleston
1987	April 28 - May 2	Charleston Place/Omni
1988	April 26 - May 1	Charleston Place/Omni
1989	April 25 - April 30	To be determined
1990	April 24 - April 29	To be determined

- AMERICAN MEDICAL ASSOCIATION -

ANNUAL MEETINGS 1986 - June 15-19, Chicago, Marriott Hotel
 1987 - June 21-25, Chicago, Conrad Hilton Hotel

INTERIM MEETINGS 1985 - December 8-11, Washington, D. C., Sheraton
 1986 - December 7-10, Las Vegas, NV, Las Vegas Hilton
 1987 - December 6-9, Atlanta, GA, Marriott Marquit

NATIONAL LEADERSHIP CONFERENCE - February 20 - 23, 1986

- MISCELLANEOUS -

September 22-27, 1985 "Review and Update in Medicine," S. C. Institute for Medical Education & Research, Mariners' Inn, Hilton Head Island.

September 26-28, 1985 "Fifth Annual Conference for Trustees, Physicians and Administrators," SCMA, S. C. Hospital Association, S. C. Association of Hospital Governing Boards, Hotel Inter-Continental, Hilton Head Island.
(See insert elsewhere in this Journal)

October 3, 1985 "Physicians' Role in Child Abuse: Prevention, Treatment and Collaboration," SCMA, SCMA Auxiliary, S. C. Chapter, American Academy of Pediatrics, S. C. Pediatric Society, S. C. Academy of Family Physicians, Carolina Inn, Columbia.

For additional information on any of these meetings, contact the SCMA Office of Information, 798-6207.

CHIROPRACTIC ON TRIAL

The American Medical Association, American Hospital Association, the JCAH, and others, have won an important preliminary court victory in a Sherman Anti-Trust action brought by the Chiropractic Cooperative Association of Michigan.

Judge Ralph M. Freeman, who is trying the case in the U. S. District Court for the Eastern District of Michigan, Southern Division, has rejected the plaintiff's motions to deny affirmative defenses of "public interest and patient care" and "laches and unclean hands." The ruling, in effect, means that chiropractic will be going on trial. Trial date has been set for March, 1986.

The plaintiff, an association of 21 Michigan chiropractors who were incorporated for the specific purpose of prosecution, have contended that the AMA and other defendants have attempted to monopolize and have conspired to monopolize certain health care markets. They had sought a per se rule application that the defendants had "unreasonably" restrained trade in violation of the Sherman Anti-Trust Act. Application of that rule would have denied any possible justification or motivation by the defense.

As part of their defense, the defendants have contended that their actions have fostered free competition and protected consumers of health care services from exploitation through deception and the hazards of unscientific treatment. Any anti-competitive effect, they maintain, is justified by concern for the public health and patient care.

GUIDELINES FOR SCMA COMMITTEES

With the approval of the new SCMA Constitution and Bylaws, the Commission structure was eliminated. Previous guidelines for committees, including the reporting process, staff assistance, routine correspondence, meetings and Minutes, are currently undergoing revision to conform to the new Bylaws.

Chairmen of Committees may expect copies for their use by early fall. Guidelines for members of the Board of Trustees have already been distributed.

CAPSULES

...*Edward F. Parker, M. D.*, a former President of the SCMA, retired July 1 from his posts as Professor Emeritus of Cardiothoracic surgery at the Medical University of South Carolina, and Chief of Thoracic Surgery at the Veterans Administration Medical Center in Charleston... The following physicians have recently been awarded honorary membership status in the SCMA: *Albert E. Cremer, M. D.*, *Ritchie H. Belser, M. D.*, *S. Edward Izard, M. D.*, *George G. Durst, Sr., M. D.*, and *Paul T. Hopkins, M. D.*

DHEC MEASLES AND RUBELLA GUIDELINES

DHEC requests the cooperation of physicians and college officials in forming a partnership to reduce the chance of measles or rubella disease on college campuses.

In 1985, 18.5 percent of the 1,802 reported cases of measles in the U. S. occurred on 25 college campuses in 14 states and the District of Columbia. The most serious outbreak on a college campus resulted in 128 cases of measles reported with three deaths in a population of less than 1,500 students.

Based on DHEC's recommendations, most universities and colleges in the state will establish measles and rubella immunity guidelines for college attendance beginning with the fall, 1985 or spring, 1986 semesters. These recommendations will affect undergraduate and graduate students born on or after January 1, 1957.

Requirements for measles and rubella immunity vary slightly from college to college, but usually include the following: (1) documented proof of measles immunity; by the date of measles immunization, or laboratory evidence of immunity, or a physician's statement of disease history. (Note: measles immunization must have been received on or after the first birthday and since 1/1/68, and a measles immunization prior to 1968 should clearly state that a live virus vaccine was administered without Immune Globulin.) (2) documented proof of rubella immunity by the date of rubella immunization or laboratory evidence of immunity. A physician's statement of disease history is not acceptable. Exemptions will be allowed for medical or religious reasons.

Physicians can anticipate a large number of requests for measles and rubella immunizations or record updates. For additional information, contact *DHEC's Division of Immunization and Prevention in Columbia at (803) 758-5621, or your local county health department.*

SEXUAL ASSAULT EXAMINATION KITS AVAILABLE

A new sexual assault kit is now available through the South Carolina Law Enforcement Division to any licensed health care facility providing sexual assault examinations. The kit provides a standard sexual assault exam protocol developed by the S. C. Law Enforcement Division and the S. C. Hospital Association. There is no charge for the kit and any facility upon completion of a sexual assault exam may file for reimbursement directly to the S. C. Crime Victim's Compensation Fund.

The purpose of this new kit is to provide health care facilities with the necessary materials for the collection of evidence, to promote coordination and hopefully move toward standardization in this area.

For further information, contact Patsy Rauton Habben, SLED, (803) 758-6070.

AN APPROACH TO TREATING SEVERE OSTEOPENIA (OSTEOPOROSIS)*

HOWARD R. NANKIN, M.D.**

Osteopenia is a comprehensive term for reduced bone mass, and includes osteoporosis, osteomalacia, and osteitis fibrosa. During the past few years we have seen much written about preventing or delaying osteoporosis in healthy women who are close to or just beyond the menopause.¹ This review will not address these individuals. On the other hand, less data are available concerning women with severe osteopenia (osteoporosis) — women who have lost more than one inch in height; women who have demonstrable atraumatic vertebral collapse; and women requiring complete bed rest or very little physical activity because of debilitating bone pain. Over the past decade we have had the opportunity to evaluate and treat such individuals and have achieved reasonable success. Until recently, success was characterized as no further atraumatic fractures, no further height loss, reduced pain, and increased strength and activity. With the current availability of estimating bone mineral content, we plan to evaluate patients annually to follow changes.² This will add a quantitative assessment to monitor therapy.

This report reviews osteopenia, outlines the workup for suspected osteopenic patients, and describes therapy. We outline our current therapy which incorporated protocols supported by the research of other groups. The current approach puts these components together in a cohesive package. Our experience with 17 patients is given.

Skeletal Structure: Bone continues to grow through childhood and reaches a maximum mass in young adults. The peak calcium content in bone is about 1,000 grams in men and about 750 grams in women. Bone is composed of osteoid (non-mineralized matrix which is 95% collagen) and

calcified minerals (largely hydroxyapatite). Bone is constantly being remodeled (resorption followed by new osteoid formation with subsequent mineralization) by osteoclasts and osteoblasts. This process occurs primarily at the periosteal, endosteal, and haversian systems. The osteoblasts form collagen and these cells then become osteocytes and somehow facilitate calcification.

As men and women age, bone mass progressively reduces. Around the menopause women lose a substantial portion of bone mass — between two to four percent per year for about four or five years, and they lose about two percent per year thereafter. After age 40, men lose about 0.5% of bone mass per year. Therefore, women begin with a smaller bone mass and experience an accelerated loss of bone when compared with men. This combination of menopausal bone loss (women) and senile bone loss (men and women) affects primarily the axial skeleton and trabecular bone. Exactly why this happens is not clear, but possible contributing factors will be addressed under *Therapy*. (See references ¹⁻⁶ for a comprehensive review).

Bone Physiology: The skeleton serves as a storage depot for calcium and phosphate, supports and protects the body, and is a buffer system for compensation of acidosis. Sometimes metabolic functions can take precedence over the structural role for bone.

Three hormones are primarily involved with calcium, phosphate, and bone homeostasis. Parathyroid hormone is produced in the parathyroid glands, lying in the neck, either on the surface or within the substance of the thyroid gland. Parathyroid hormone is released when circulating levels of calcium fall, and is rapidly degraded in the kidney and in the liver. This hormone increases bone resorption by stimulating activity of both osteoclasts and osteocytes, which releases both calcium and phosphate into the blood. While in the kidney, tubular reabsorption of phosphate is reduced and calcium reabsorption is increased by parathyroid hormone. Reduction in phosphate

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concentration stimulates the kidney to produce the active form of Vitamin D.

The precursor form of Vitamin D originates in the skin or diet and is converted in the liver to form 25(OH)D₃ (calcifediol). This is converted to the active form of Vitamin D (1,25(OH)₂D₃ calcitriol) by mitochondrial enzyme systems in cells of the proximal convoluted tubules of the kidney. The active form of Vitamin D increases intestinal absorption of calcium and phosphate, it both stimulates bone resorption but also stimulates bone mineralization, and it also directly stimulates the synthesis and maturation of collagen.

In the parafollicular cells (arising from the ultimobranhial bodies), scattered in the thyroid gland, a peptide hormone is secreted in response to rising levels of circulating calcium. This peptide, calcitonin, decreases osteoclastic bone resorption which enhances accretion of calcium into bone, and it may also increase urinary excretion of calcium.

Osteopenia: This is an inclusive term for reduced bone mass which is expressed clinically as bone pain, fractures, and deformity. Osteomalacia, osteoporosis, and osteitis fibrosa are each forms of osteopenia. These may occur simultaneously and all bones may not be equally afflicted.

Osteomalacia is impaired mineralization of bone, with or without decreased total bone mass. In children this is rickets. This can be associated with osteitis fibrosa due to secondary hyperparathyroidism or with osteoporosis in older patients. Causes of osteomalacia include Vitamin D deficiency or resistance. Malabsorption of calcium, phosphate, and Vitamin D can cause osteomalacia. Liver or renal disease which would interfere with the biosynthesis of the active form of Vitamin D can cause this disorder. Anticonvulsants may either inactivate Vitamin D products or antagonize the active form of Vitamin D peripherally.

Osteoporosis is a generic term for several disorders, and is probably the most common form of osteopenia. It is defined as a decrease in bone mass with proportional losses of matrix and mineral. It tends to involve primarily the vertebrae and the ends of long bones (trabecular bone). There are several classifications for osteoporosis and these include: involutional, which is probably multifactorial; idiopathic, results in rapidly progressive

axial bone loss in young to middle-aged men; juvenile osteoporosis also involves the axial skeleton and begins in puberty with spontaneous remission — the cause of this and idiopathic are unclear; immobilization can cause significant osteoporosis in a relatively short time; hypogonadism in males or in females can cause reduced bone mass; and in osteogenesis imperfecta the cause is abnormal matrix. Involutional osteoporosis includes menopausal (which affects primarily axial skeleton) and senile (which is thought to be a generalized process) components in females.

Excessive production of parathyroid hormone stimulates osteoclastic activity out of proportion to osteoblastic activity. This can occur because of parathyroid hyperplasia or adenomas, and can also occur in renal failure or in osteomalacia. The appropriate treatment is to reverse the excessive production of parathyroid hormone.

Several conditions can result in osteopenia. In patients, glucocorticoids decrease bone formation, decrease calcium absorption, stimulate parathyroid hormone secretion, and impair bone mineralization as well as decrease production of bone matrix. Whenever possible, glucocorticoids should be reduced or discontinued. If needed, glucocorticoids should be given on a once-a-day schedule, or better yet, once every other day — if possible — to reduce side effects. Patients on long-term glucocorticoid therapy should be given calcium and Vitamin D supplements, sex hormone therapy if appropriate, and be monitored for worsening osteopenia. These steps can help reverse the negative calcium balance these patients experience.^{3, 4} Hyperparathyroidism of any etiology increases dissolution of bone and should be excluded in patients presenting with bone disease. Diabetes mellitus is also associated with osteopenia because of impaired activation of Vitamin D, and reduced insulin stimulation of bone collagen synthesis. Malignancy can be widespread in bone and run a chronic course. Myeloma is perhaps the most common malignant disorder that can produce lytic lesions of bone or generalized loss of bone. Other malignancies can also produce similar changes, through a variety of direct and humoral mechanisms. Therefore, all patients presenting with osteopenia should be screened for cancer.

Diagnosis of Osteopenia: The accompanying Table I describes the common laboratory results

OSTEOPENIA

TABLE I

<i>Test</i>	<i>Osteoporosis</i>	<i>Osteomalacia</i>	<i>↑PTH</i>
Serum ionized calcium	N	N to L	N to E
Serum total calcium [°]	N	N to L	N to E
Serum PO ₄	N	N to L	N to L
Serum alkaline phosphatase	N	N to E	N to E
Serum PTH	N	N to E	N to E
Serum 1,25 (OH) ₂ D ₃	N to L	L	E
Serum Urine cAMP	N	E	E
Urine calcium/24h	N to L	L (except RTA)	N to E
Urine hydroxyproline	L	L	E

N = Normal; L = Low; E = Elevated

[°] Corrected calcium is obtained by adding 0.8mg% calcium to the determined calcium value for each 1.0 gm% deficit in serum albumin. Normal albumin = 4-4.5 g/dl.

with osteoporosis, osteomalacia, and osteitis fibrosa (increased parathyroid hormone). Some of our patients had laboratory evidence of osteomalacia, but that disorder cannot be excluded in the rest and osteoporosis is largely a diagnosis of exclusion.

Conventional x-ray studies are insensitive until there is a substantial loss of calcium. However, if the patients have multiple collapsed vertebrae, wedging, cod-fish vertebrae, and demineralization, the diagnosis is supported. In osteomalacia pseudofractures may be seen. There are now techniques to determine calcium content in bone. The first method involves dual photon absorption and uses radioactive nuclides. The second technique involves computerized tomography using calcium standards and a special program. Both of these techniques give precise estimates of calcium content in the top four lumbar vertebrae.² This is the best noninvasive way to assess the calcium content of bone. Forearm single photon absorption until recently has been used as a screening test to define those individuals with increased likelihood for reduced axial bone. Because forearm bone may not reflect vertebral, lumbar studies were then performed to more precisely define the mineral content. Perhaps some of the newer instruments, utilizing advanced programs, can also estimate trabecular bone content in the very distal portions of the forearm and this may also be useful in determining those individuals at risk for axial diseases.

In some centers through and through biopsies are taken of the iliac bone, processed using special techniques, and then studied using morphometric approaches. Such studies enable more precise definition of the bone problem in an individual. However, such a biopsy does not seem to be essential at present unless the presentation is unusual or there is a poor therapeutic response. The treatment of osteomalacia and osteoporosis in aging females is very similar.

Risk Factors: Osteopenia occurs most commonly in woman who have a combination of the following — slender white female, early menopause or many years since the menopause, cigarette smokers, individuals who do not take in adequate calcium, women who are not physically active and who have a family history of this disorder. Other risk factors include diabetes mellitus, alcoholism, and poor nutrition. It is thought that older people also take in less calcium and Vitamin D, have less exposure to sunlight (which would help synthesize Vitamin D) and the enzyme responsible for 1-alpha hydroxylation of Vitamin D — the final step in active Vitamin D formation — is reduced with aging. In general, the patient needs an adequate nutritional intake. Reduced phosphate can reduce osteoblastic matrix synthesis. Although black women lose bone in parallel fashion to white females, they begin with more mass and osteoporosis is rare in blacks.

Workup: In patients with a protracted course of symptoms and features of bone disease lasting more than six months, with no overt malignancy, the diagnosis is most probably osteopenia. In people with relatively short duration problems (less than six months) the chance for malignancy is increased. A complete history and physical examination, mammography, blood count, biochemical profile, spine x-rays, thyroid function tests, urinalysis, chest x-ray, and serum protein electrophoresis seem to be an adequate beginning. If any of these studies are abnormal, appropriate evaluation should be done. These patients generally have either low or low-normal levels of serum calcium. If the concentrations are high-normal or elevated, then multiple serum calcium levels should be determined and the patient evaluated for all of the possible causes of hypercalcemia. We have seen patients present for osteopenia therapy who have had previously undiagnosed lung cancer, hyperparathyroidism, and spinal stenosis. Appropriate therapy for heart disease, hypertension, and diabetes mellitus do not seem to interfere with the treatment outlined below. We have not used this aggressive approach in treating people with advanced renal disease and management of those patients will not be included in the current report. Patients on chronic adrenal therapy also may benefit from appropriate treatment, but will not be discussed in this report either.^{3, 4}

Treatment: The patients with severe osteoporosis and osteomalacia may be bedridden due to constant pain, and sometimes they are unable to move in bed without exacerbating their discomfort. We attempt an expedited workup. The pelvic examination or the mammography may be deferred for a few days until they start to feel better. With significant discomfort, many of these patients are unable to properly feed themselves and a mechanical soft diet is often preferred. Because of the high incidence of constipation, we have the patients sprinkle one teaspoonful of bran fiber on their breakfast and this may be increased after three days to one teaspoonful twice a day if constipation persists. These patients are commonly on a wide variety of analgesics and narcotics. For analgesia, they are switched to acetaminophen, 325 mg with codeine phosphate, 64 mg, one tablet every four hours as needed, and every third day the codeine is reduced by 50% until by 10-12 days, the patients take PRN

acetaminophen alone. If they are having muscle spasm, diazepam, 2 mg is given every six hours for the first three days. This is then reduced to every eight hours, and then to every 12 hours at three-day intervals, and then discontinued. Heating pads or hot water bottles to the painful spine is often helpful. While it is therapeutic for the patients to get out of bed, to sit up, and to walk, it may take several days before either of these can be accomplished. We try to follow the theory that if any activity hurts, then it should be avoided. There are several braces that help to support the back and can relieve some of the pain patients suffer and an orthopedic consult may be helpful. Physical activity is encouraged and activities associated with weight-bearing appear to stimulate bone mass.

Vitamin D: These patients may have reduced intake of this vitamin, reduced absorption of this vitamin, and the conversion of precursors to the active form may be reduced in the elderly.^{5, 6} We obtain a serum specimen for 1,25-dihydroxy D₃ (calcitriol) and send it to Nichols Institute. It takes about two weeks for the result, so that treatment is begun after the specimen is drawn. Patients are begun on oral calcitriol (Rocaltrol) 0.25 micrograms daily. If the baseline level of calcitriol comes back in the normal range, they may be switched to cheaper Vitamin D₂ (Calciferol) 50,000 units every Sunday. If the basal value comes back low, they are maintained on the oral calcitriol. Vitamin D administration is included in virtually all protocols for treating osteoporosis and osteomalacia.^{3, 4, 6}

Calcium: In addition to diet, those patients should be given 1.0 to 1.5 grams of calcium supplement daily. Currently, calcium carbonate appears to be the easiest form of medication to use. The patients may be given the total dose at bedtime, or it may be divided up during the day, whichever the patient prefers. These tablets are labeled by calcium content. A 250 mg tablet is easier to swallow than a 500 mg pill. Some patients choose calcium lactate or calcium gluconate or other forms of calcium — whatever form is used, the amount of calcium given should be maintained to at least 1 gram per day, (calcium content: calcium carbonate = 40%; chloride = 30%; lactate = 16%; gluconate = 10%). In some preliminary reports it has been suggested that

ground-up bovine bones have theoretical advantage to other forms of calcium supplement, as they contain balanced minerals derived from bone, but data to firmly support this are not available. These British reports suggest 6 grams of the ground bone daily. (See addendum.)

Hydrochlorothiazide: This diuretic has a well-documented renal action which reduces the amount of calcium lost in the urine. Independent studies have shown that 25 mg per day enhances bone mass.⁷ While we utilize this drug in our treatment, controlled studies utilizing this medication have not been performed on women presenting with osteoporosis, but current data suggest that it should be helpful.³

Diet: The patients should be on balanced nutritional intake as adequate matrix formation will not occur otherwise. They should be ingesting dairy products (as primary calcium and phosphate sources), and if they have lactose intolerance, they may use yogurt or milk treated to metabolize the lactose (LactAid). The diet should supply at least 500 mg of calcium.

Hormone Therapy: Unless there are known contraindications (residual breast cancer, residual endometrial or uterine cancer, tendency to thrombophlebitis, or hypertension which is made worse on these hormones) patients are started on cyclical estrogen/progesterone and testosterone therapy. The women are given conjugated estrogens, 0.625 mg days one to 25 of each month, and medroxyprogesterone acetate, 10 mg days 16 to 25 of each month. All women are given cyclical therapy in this fashion, even if a uterus has been removed and if the patients have undergone simple mastectomy (some residual breast is commonly left behind). Currently available epidemiological data suggest that women on this therapy have a lower incidence of breast cancer and a lower incidence of endometrial cancer, and live longer than control women who are not given cyclical therapy.⁸ Progesterone down regulates estrogen receptors in the breast. Estrogen appears to reduce bone resorption and appears to antagonize parathyroid hormone.^{9, 10} Progesterone has separate additive beneficial effects in treating osteoporosis.¹¹

Androgens have been used to treat osteoporosis for several decades.^{3, 12} They may have two sepa-

rate actions — increasing intestinal absorption of calcium, and direct effects on stimulating bone formation. We have used injectable testosterone cypionate or testosterone enanthate in combination with the above female hormones. For women weighing less than 80 lbs., 25 mg is given early in each month, while those women weighing more receive 50 mg monthly. When given in combination with estrogens, no virilizing changes have been noted. For convenience, some women prefer receiving an injection of estradiol valerate, 10 mg monthly with the testosterone injection. In those women, the oral estrogen is omitted, but they are still cycled on progesterone.

Women on cyclical female hormones may experience monthly withdrawal bleeding. They should be warned of this in advance. The first month or two menses may be somewhat heavier. Some women who are years beyond the menopause do not experience monthly bleeding even with an intact uterus. There is no absolute cutoff time to hormone therapy. Patients should be assessed periodically. The current feeling is that hormones started at the menopause be continued until age 65 years (M. Notelovitz, personal communication).

Calcitonin: This synthetic, injectable form of medication has recently been approved for use in treating osteoporosis. Calcitonin antagonizes osteoclastic activity. We have only limited experience with it and are not using it routinely. Since the commercial preparation is modeled after salmon calcitonin, each patient should be skin-tested with one unit as per the package insert before long-term therapy is utilized. The daily injection of 100 units for 24 months was shown to increase bone calcium and to improve histologic assessment.¹³

Intravenous Therapy: There have been several reports suggesting that intravenous calcium (using larger dosages but without hydrochlorothiazide) may be helpful when conventional forms of therapy do not work.^{14, 15} In addition, appreciable calcium may be delivered directly into the circulating blood and patients appear to feel better more quickly. Our patients are begun on all of the medications as noted above, plus they are given 200 mg of calcium (either as calcium gluconate or calcium gluceptate) in 400 ml of 2.5% (or 0.2% saline, in diabetic patients) dextrose with multi-

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DR. PORCHER IN PARIS: A SOUTH CAROLINIAN'S IMPRESSIONS OF TWO MAJOR FRENCH SURGEONS OF THE MID-NINETEENTH CENTURY

W. CURTIS WORTHINGTON, JR., M.D.*

Dr. Francis Peyre Porcher (1825-1894) was an honor graduate of the Medical College of the State of South Carolina who went on to distinguish himself both locally and nationally. He was a renowned botanist whose book, *Resources of the Southern Fields and Forests*, written during the Confederate War, is said to have "saved the Confederacy for two years," because it described local substitutes for medicines in short supply as a result of the Federal blockade. He served on the faculty of the Medical College and in leadership capacities in local, state, national and international medical organizations. His frequent and original papers were on topics in the medical field as well as outside it, and he was friends with many of the most important people in medicine, botany and literature of his time.

It is not surprising that a man of his intellectual bent spent several years on the European continent, not only for the purpose of expanding his medical and botanical knowledge but in learning more of the old world and immersing himself in its culture.

Large numbers of physicians from outside France made Paris their "mecca" for finishing off their medical studies and by the second or third decade of the 19th century had replaced, at least in part, London, Edinburgh and Leyden as the favorite European center for Americans. There were large numbers of them there, especially in the 1830's, and many of them came from the Medical College of South Carolina, following in number only below Pennsylvania and Harvard and by the 1850's exceeding even Harvard.

In the course of his stay in Paris, Porcher made every effort to study medicine as it was practiced there and especially to observe the great physi-

cians and surgeons of that city as they went about their work and to learn as much as he could about them as individuals. He was an excellent observer and insightful in analyzing personalities and his accounts of two major surgical figures in Paris not only tell us a great deal about those figures through the eyes of an unbiased observer but also quite a bit about the attitudes and interests of Francis Porcher.

Porcher kept several notebooks on his travels in Paris and other parts of western Europe which describe for the most part his non-medical experiences. These have not been published. Of his observations of medical practice in Paris and the personalities involved, he wrote several reports to *The Charleston Medical Journal* and prominently featured in these reports were two of the most prestigious French surgeons of that period.

He sets the stage for his account of the better known of the two by leading us into the hallways and wards of the Hôpital De La Charité early on a winter's morning, describing in beautiful and lucid detail the physical structure and the people inhabiting it including French, German, Italian and, above all, American students. His description of the American student is quite consistent with the attitudes of our students in the present day.

At this point, I will let Porcher speak for himself.

"Far from where you enter stand a throng of men, some crowding around a particular bed, some with hats on, others uncovered; from out their number moves an individual whom you did not, at first, observe, but whom every one seems to follow, as he passes rapidly from one bed to another, squeezing his way in among those encircling him. He is a person with a sharp, greyish eye, of middle height, more tall than short, inclined to be thin, and moving unobscuringly by, unless when he stops, occasionally, as the inclination seizes him, to ask

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some question of a favourite chef-de-clinique, or of a sister. He will sometime not speak or smile for a half hour, unless on the subject of medicine, or the case before him; at other times, he even smiles and makes a little dry fun with the sick man, though he never laughs, and often, if induced to relax at something particularly ludicrous, he soon recovers himself, becomes grave, or rather I should say earnest, and his eye looks as piercing as before. Neither his voice nor manner is soft or winning, although they show, when he speaks to a boy, or the gravity of the case is imminent, that his heart is feeling, and that even habit, time and the knife have not made him entirely callous to the sufferings of the unfortunate. I have heard him quiz a little *Interne* with white hair, upon the colour of his moustache; but it was not done in a genial way, it was as a surgeon would quiz, and you only laughed because the great man laughed. He, also, wears a white apron with pockets, from which dangle a pin-cushion, and on his head is a purple velvet skull cap, with tassel. Thin grey hair escapes from beneath, and you are quite surprised when, upon inquiry, you are told that that is the great surgical Amphictyon of La Charité and of France, M.

Velpeau."

Velpeau must have been a man of prodigious energy. Porcher proceeds to describe his full operating schedule, stating that he would cut for the stone, operate two or three times for cross-eye, remove two or three breast tumors, and do one or more amputations on almost any morning, after ward rounds and an hour's lecture. Later in the day, he saw to his private patients and made house calls. Velpeau's reputation was also prodigious and Dr. Porcher describes in rather extravagant terms "the bold generalizer, who has laid a master hand on almost every department of medicine; who has written a hundred volumes, whom everybody quotes, . . . he has made a specialty of every department of his profession, and has rendered himself as competent to pronounce upon their respective merits as any enthusiast of a single one, whether it be in surgery, materia medica, obstetrics, physiology, diseases of the eye, or anything else you please to name."

Porcher goes on to comment on his literary output and great influence.

Lest all of this give the impression of hero worship, Porcher regards the great man in a very objective light on several matters. He points out that "the microscopists will make him rue the day

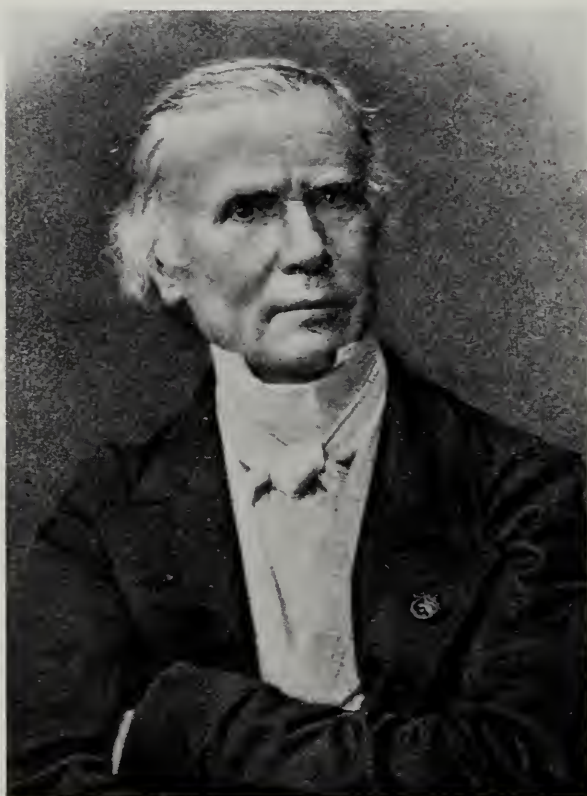


FIGURE 1. Alfred-Armand-Louis-Marie Velpeau.



FIGURE 2. Velpeau at a younger age.

that he decided too dogmatically against their true and false cancers; . . .". Velpeau had evidently taken a stand against the microscopic diagnosis of malignant disease in favor of a simple physical examination! Porcher cites other errors that he thinks Velpeau made and comments, "An old man, however great, is apt to remember triumphs won in youth from giants, and he grows too confident thereby."

Nevertheless, Porcher goes on later to say that "Velpeau, clothed in the ancient heavy armour of the veteran, still bears about him the keen and trenchant sword, as sharp and polished as that of any youthful champion around him. He may hedge himself in with precedent and experience, but he is constantly re-examining his precedent, and weighing and comparing his experience with that of others, whilst none contribute more fresh additions to them than himself."

Velpeau was, according to Porcher, a not remarkable lecturer, although "sufficiently fluent and pleasant." Apparently his French was easy to understand but his delivery was not characterized by "eloquence nor any brilliancy." His attraction to Porcher was his fame, knowledge and "the perfect flood of light which his vast experience enables him to throw on every subject." Porcher obviously admires Velpeau's operative technique and yet compares his ambidexterity unfavorably to that of the American, Valentine Mott.

Porcher considered it singular that Velpeau spoke no English, holding that if someone did not speak French, it was his own misfortune. This remarkable man, who obviously made such an enormous impression on Porcher, was born poor, the son of a blacksmith. He arrived in Paris in 1818 with less than 400 francs and rose, through natural ability and hard work, to the high estate that he held when Porcher knew him in 1853.

In introducing the second of the major surgeons in Paris, Porcher dwells more on the history and antiquity of his hospital, the Hotel-Dieu, than on its physical arrangement as he did in the first. He feels that the Hotel-Dieu, built on "the Isle and in the ancient *Cité*" is "more classic" than La Charité and is steeped in more ancient lore having "more of antiquity," near to Notre Dame and "many associations connected with Saint Louis and the old bishops and reverend prelates of early times. Kings and pontiffs patronized and endowed her, and she was later taken into the bosom of the church as one of the most important and



FIGURE 3. Philibert-Joseph Roux.

sacred of her institutions for ministering to suffering humanity, . . .".

The second of Porcher's two "Ajaces" of surgery was the Surgeon-in-Chief of the Hotel-Dieu and a man who stood in stark contrast in many respects to his opposite number at La Charité. Philibert-Joseph Roux is described as "a large, blunt, free spoken gentleman" with "Atlantean shoulders' and corresponding size of head" who was brusk, amiable and who lorded it over the younger members of the profession at the Hotel-Dieu. He had died a few months before Porcher wrote his report but had built up a tremendous reputation over a lifetime in medicine. He was, as in the case of Velpeau, viewed by Porcher with high respect but less than awe and on some points of his character and behavior quite realistically.

For example, Porcher describes his "lively and jocose" bearing and how relaxed and informal he was with the students and assistants. He also refers to "mannerisms," one of which at least must have been unpleasant or, at best, embarrassing to the individual who was on the receiving end of it. Porcher says that he was "given to all kinds of motions, both of face and hands, . . ." and described an episode which can only leave you with the impression that the great man at times bor-



FIGURE 4. La Charité in the 1830's.

dered on being a buffoon. He says: "I have seen him when M. Gosselin was lecturing in his place making every variety of wry faces, twirling a pair of surgical scissors about, performing imaginary operations with it against the air, and actually attracting more attention from the lookers on, in his temporary capacity as second, than did his junior who all the while was speaking so much better than Roux ever could. M. Roux had the most execrable delivery possible to be conceived of."

Porcher goes on to a highly unflattering description of Roux's speech and delivery and doubts that even a young French student newly arrived in Paris from the provinces could understand him.

The manifestations of a thoroughly extroverted personality and failure as a public speaker aside, Porcher was unstinting in his praise. He refers to Roux's role as a link between the preceding generation of French surgeons, such as Dupuytren and Bichat and the contemporary one represented by Velpeau and others and with admiration and (significantly for the medical politics of the time?) points to his having obtained the highest honor in one of the oldest and greatest hospitals in Europe by his "fitness and ability" rather than some simple right of priority. Roux "quailed before no surgical operation within the reach of human interference" and when he "had pronounced upon a question of surgery, the matter was decided. There was no appeal, for where was there a higher tribunal?"

Roux was not a prolific writer and, although he published a number of creditable works, his reputation rested more particularly on his surgical skill. Like Velpeau, he was able to innovate successfully. Porcher mentions especially his contributions to the surgery of the palate and cataract. Other important characteristics of the man were his audacity at the operating table and his coolness under pressure, both of which undoubtedly contributed significantly to his reputation and success. Again, with considerable flourish, Porcher describes Roux, "in the midst of the most trying crisis of the operation, when dangers thicken, disaster stares in the face, when arteries are spouting, pulses ebbing and life itself on the wane, and whilst dismay is depicted on all around, he alone — cool, calm and dispassionate — seems by some master stroke or unseen resource to snatch victory from defeat; . . .".

Roux was active up until the very end of his life and appeared to have suffered no loss of ability or his ebullient outlook with advancing age. He died in 1854, not unsurprisingly, from a stroke.

Roux had not risen from such humble origins as Velpeau but, like Velpeau, had come a long way. He had been born in a small town, the son of a surgeon, and by modest steps had taken advantage of his native ability and industry to rise to a major position in French medicine. That he and Velpeau were rivals, albeit probably friendly ones, can be deduced from Porcher's observation that the two major surgeons' positions (at La Charité and Hotel-Dieu) were pitted against each other



FIGURE 5. Hôtel Dieu in 1836. Its close proximity to Notre Dame shows clearly with the cathedral's towers in the background.

and when the issue of Velpeau's replacing Roux at the Hotel-Dieu arose, Velpeau's friends were concerned that such an action might imply that the position of Chirurgien-in-Chief at La Charité was the inferior position. Be that as it may, Velpeau was a principal eulogist and mourner at Roux's funeral and Porcher was convinced that his oration was sincere. Porcher seems to have known that Velpeau and Roux were intimate friends; a friendship, perhaps, born of the very rivalry inherent in their respective positions.

A comparison of the two men drawn from Porcher's account is most interesting for its contrasts. Velpeau, grey eyes; tallish; thin; moving rapidly but without perceptible discontinuities in his forward progress through the wards; dry wit; bookish, with large literary output.

Roux, large; portly, imposing presence; hearty sense of humor; capable of lifting a colleague out of his way with a bear hug from behind with ease; "unbounded bon homie;" "a favorite everywhere;" competently literary without a large output, and always the man of action.

Porcher's reminiscences of these two giants of surgery in Paris in the mid 19th century serve to

give us a glimpse of the surgeons of that time; their attitudes, concerns and manners and, perhaps, also, to remind us that while medical science changes drastically, and sometimes with frightening rapidity, human nature and diversity of personality in medicine do not. □

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WHAT YOU SHOULD KNOW BEFORE YOU BUY STOCK

Successful investing requires more than good luck.

Isn't it amazing how even sophisticated investors can do little more than babble when contemplating whether or not to buy a stock? After all, how many times have you invested thousands of dollars in a stock recommended by your unemployed brother-in-law? And how many times have you vowed never to do so again until your cousin in Des Moines called with yet another sure-fire tip?

The stock market is a hobby to some, a vocation to others - a passion, a plague, an obsession to different segments of the American public. It is a place where you can pursue your most fantastic dreams. But it is also a place where you can achieve realistic goals...provided, of course, you approach it with the same common sense that helped you earn the money you're now planning to invest.

How should you Begin?

First, realize that while many investors have "gotten rich quick" in the stock market, they are the exception, not the rule. Temper your expectations and don't put all your eggs in one issue. Diversification can help reduce risk and enhance your return over the long run. Remember -- even the best conceived investment strategy can be rendered worthless by unforeseen events. Protect yourself and always think in terms of compiling a diversified portfolio, rather than purchasing one or two stocks. Also, ask yourself the following questions before you can take the plunge:

Can you afford to lose the money you invest? Even conservative investments have been known to backfire.

Do you have the temperament to buy stocks? Or will price fluctuations, no matter how small, cause you to lose sleep at night?

And do you have the objectivity to let your profits ride and to cut your losses short?

In any case, the logical starting point is you...examining your own objectives. Since there's no "one size fits all" stock, it's going to take a little digging on your part to find the perfect fit. How do you get started?

(Next month I will continue with a discussion on "Making your Selection.")

Piecemeal Tax Planning Can Be Hazardous to Your Financial Health

Continued from Last Month's issue.

There are relatively inexpensive plans which concentrate on meeting a specific number of particular goals that may range from an education for your childred to a home on Cape Cod. In contrast, some other plans focus on a person's full financial picture, in order to help him or her meet a variety of objectives simultaneously and most effectively. These plans can include everything from retirement to estate planning, from reducing taxes to providing life insurance, or all of these considerations and more. However, even these comprehensive plans vary in form. Some provide investors with a plan in the form of a hundred-page manuscript. Others boast highly personalized services, including periodic consultations with professionals to review the plan.

Who's the right planner for you?

To some extent, the way a financial plan is developed depends on who's doing the planning. Independent financial planning organizations have proliferated across the country during the past few years, but they don't hold a monopoly in the field. Currently, there are insurance firms, attorneys and accountants who perform financial planning services. Some planners, of course, are more qualified than others and you may want to do some investigating of your own before placing your trust (and all your financial information) in the hands of just any financial planner.

Several brokerage firms (E.F. Hutton in particular) provide financial planning services. Services from well-respected brokerage houses are often valued, since investors feel these firms have the most knowledge about the investments they recommend as part of the financial plan. And contrary to the beliefs of some investors, programs offered by brokerage firms can be suprisingly impartial. E.F. Hutton, in fact, prides itself on offering generic recommendations such as "consider establishing a Clifford Trust and funding it with government securities or conservative stocks." Which government securities or conservative stocks is left up to you and your Account Executive.

All in all, there is a wide variety of financial planning alternatives at your fingertips, many of which can provide invaluable assistance in helping you get from here (current financial situation) to there (your eventual goals).

So don't become easy prey for popular tax reducing schemes without considering the broader implications. Take control of your full picture with financial planning.

FURTHER INFORMATION

If you would like to receive further information on any of the topice covered in this newsletter, please write to Martin Lefkowitz, CFP, E.F. Hutton & Company, Inc. 2700 Middleburg Drive, Suite 200, Columbia, SC 29204; or Call (800) 922-1112.

* * * * *

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Editorials

Erythema chronicum migrans, *Ixodes dammini*, *Borrelia burgdorferi* — these additions to our vocabulary have been added by the recognition of Lyme disease in 1977. The occurrence of delayed neurologic or cardiac abnormalities (in stage 2 of the disease) and of arthritis (in stage 3) make the consideration of Lyme disease important in the differential diagnosis of many problems. The case report in this issue emphasizes that Lyme disease can indeed occur in South Carolina. In the following editorial, Dr. Arthur DiSalvo discusses both the distribution of the tick vector within South Carolina and also the availability of serologic testing.

— CSB

LYME DISEASE

The first case report of Lyme disease in South Carolina is described by Drs. Taylor and Harris in this issue.

Lyme disease (from old Lyme, Connecticut) was first described as a clinical entity in 1977, but the characteristic lesion of this syndrome, Erythema Chronicum Migrans (ECM), has been recognized in Europe since 1909 and was first reported in the United States in 1970.

The description of the clinical features, therapy, epidemiology and the isolation and identification of the etiologic agent of this arcane clinical entity was elucidated in less than 10 years. An epidemiological relationship between patients with Lyme disease and their activities suggested that this malady was probably caused by a rickettsia or bacterium transmitted by ticks. The appearance of ECM following a tick bite has been recognized in Europe for many years and has been associated with the tick *Ixodes ricinus*.

In 1982, a spirochete was isolated from *Ixodes dammini* ticks and in 1983, similar spirochetes were isolated from blood, spinal fluid and skin biopsies of patients with Lyme disease. Serologic studies confirmed that the isolates were the same organism and were the etiologic agent which had been sought. In 1984 the organism was named *Borrelia burgdorferi*.

The incubation period ranges from a few days to a few weeks and the patient will frequently remember a tick attachment at the site of the ECM. As with other tick-borne illnesses, Lyme disease occurs more frequently in the summer. In South Carolina, ticks are abundant from April

through October, with the greatest number in July. The onset of illness in the described case from South Carolina has the appropriate temporal association. Early reports led investigators to believe this disease was confined to New England and the range of *Ixodes dammini*. Subsequent cases showed clustering in the Midwest (also associated with *Ixodes dammini*) and in the far West (associated with *Ixodes pacificus*).

From 1974 through 1981, the Bureau of Laboratories examined 27,362 ticks for evidence of Rocky Mountain spotted fever rickettsia. The surveillance for this disease provided the opportunity to identify tick species throughout South Carolina. The *Ixodes* species *I. scapularis*, though not abundant, was found in 25 counties from Georgia to North Carolina and from the Coastal counties to the Piedmont. Recently *Borrelia burgdorferi* was isolated from *Amblyomma americanum*, (in New Jersey) a tick distributed throughout South Carolina. Although not yet reported in the literature, it has been found that *Dermacentor variabilis*, the most common tick in South Carolina, also harbors the etiologic agent of Lyme disease.

There have been recent studies that indicate that the white-footed mouse may be the reservoir of *B. burgdorferi*. This mouse inhabits the Piedmont and Sandhills portions of South Carolina.

Serologic testing is available through the DHEC Bureau of Laboratories. The serum should not be collected until four weeks after the onset of illness. Appropriate specimens will be accepted by the Bureau of Laboratories for culture of the organism. Prior consultation is required because

the isolation medium is complex and must be prepared when needed.

Skin biopsy may be used as a diagnostic tool early in the course of disease. Careful histologic examinations of skin taken from the ECM lesion will reveal the spirochete when stained by the Warthin-Starry method.

In the United States, Lyme disease now exceeds Rocky Mountain spotted fever as the most commonly reported tickborne illness. From the evidence presently available, there is no reason why Lyme disease should not be expected to occur

throughout South Carolina. The vocation, avocation and travel history of the patient should be scrutinized for possible tick association. As Louis Pasteur commented, "Chance only favors the prepared mind."

ARTHUR F. DiSALVO, M.D.
Chief, Bureau of Laboratories
South Carolina Department of Health
and Environmental Control
2600 Bull Street
Columbia, S. C. 29201

A FRENCH CONNECTION

With much justification, we endorse the notion that American medicine ranks second to none. Understandably, we sometimes forget that our country was not always the world's medical mecca.

Between 1820 and 1860, Americans looked to France for medical expertise. Among the hundreds of American physicians who flocked to Paris was Dr. Francis Peyre Porcher, whose observations are recounted by Dr. Curtis Worthington in this issue. Known as the French period, this chapter in American medical history has been told frequently and well.¹

Historical interpretation — like scientific theory — is subject to constant re-thinking. Recently, a brilliant young medical historian, John Harley Warner, has shed some new insights on the impact of the Parisians on American medical practice. What did the Americans actually think of the French clinicians? And what did they bring back to America?²

Warner suggests that Americans admired the scientific achievements of the French but tended to doubt their practicality. He submits that "even those Americans who were most enthusiastic about the promise of French medical science tended to believe that its practice embodied an

embarrassing valuation of knowledge over healing." Further, Americans often wrote home that the bedside manner of their French counterparts left much to be desired. The concern that science could corrupt the practical and even the moral sides of medicine led to a formal statement in the American Medical Association's original code of ethics: "No scientific attainments can compensate for the want of correct moral principles."

Does this interpretation hold relevance for us today? Perhaps. What do the foreign physicians who flock to American medical centers in the 1980's really think of *us*? Do they respect and envy our advanced technology — yet whisper to their countrymen that the Americans' real devotion to patient care seems inferior to their own? Do they sometimes question our dedication to the basic ethical and moral principles of our profession? Could *we*, like the Parisians, benefit from an open dialogue with our guests regarding what *they* think of *us*?

— CSB

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HAND EMERGENCIES: MORE DATA

Dr. Brent Stromberg's data on hand infections in children in this issue add to the experience reported previously from MUSC.^{1, 2} These infections were seldom due to *S. aureus* alone. They were frequently polymicrobial, and anaerobic pathogens were isolated in 27 percent of instances. Fortunately, most responded promptly to aggressive medical and surgical therapy.

Dr. Stromberg notes that penicillin and ampicillin would be poor choices for initial therapy of these infections, and instead suggests cephalosporins, penicillinase-resistant penicillins, or clindamycin. All of these agents have their drawbacks, including cost, lack of coverage against certain pathogens, and side effects. Another alternative would be the combination of a beta-lactam antibiotic with a beta-lactamase inhibitor, such as the amoxicillin-clavulanic acid combination (Augmentin). This combination has been shown to be effective therapy of bite wounds,³ and should provide adequate coverage against most of the pathogens described by Dr. Stromberg in this issue.

In the editorial accompanying Dr. Stromberg's paper last year, we emphasized the desirability of obtaining good bacteriologic data and commented on three unusual pathogens causing hand infections which might be suggested by the history: *Pasteurella multocida*, *Eikenella corrodens*, and *Vibrio vulnificus*. The value of an initial Gram's stain cannot be over-emphasized. Recently, we encountered a patient with acute cellulitis of the thenar eminence in a man who gave the history that he had tripped and fallen on a twig while being pursued through a swamp. Gram's stain revealed gram-negative rods: a presumptive diagnosis of *Aeromonas hydrophilia* infection (later confirmed by culture) was made,

and he responded to therapy which included an aminoglycoside antibiotic.

A physician in Thomasville, Georgia recently provided practical advice regarding another type of hand emergency: snakebite.⁴ Noting that snakebites involve the fingers in 21 percent of instances and that severe deformity can result, Dr. Watt describes a method of emergency digit dermatomy. He makes a longitudinal incision through the subcutaneous tissue over the lateral aspect of the bitten digit with a No. 15 blade, and then spreads the skin with a hemostat. This procedure, in his experience, effectively decompresses the digit and thus minimizes the risk of ischemic injury to nerves and small blood vessels from the tremendous edema caused by envenomation.

This year's Thomas A. Roe and Shirley W. Roe Award for the best article in *The Journal* by a practicing physician was awarded to the authors of a paper on acute hand problems.⁵ Clearly, this is the type of acute medical problem in which practicing physicians can continue to make important observations.

— CSB

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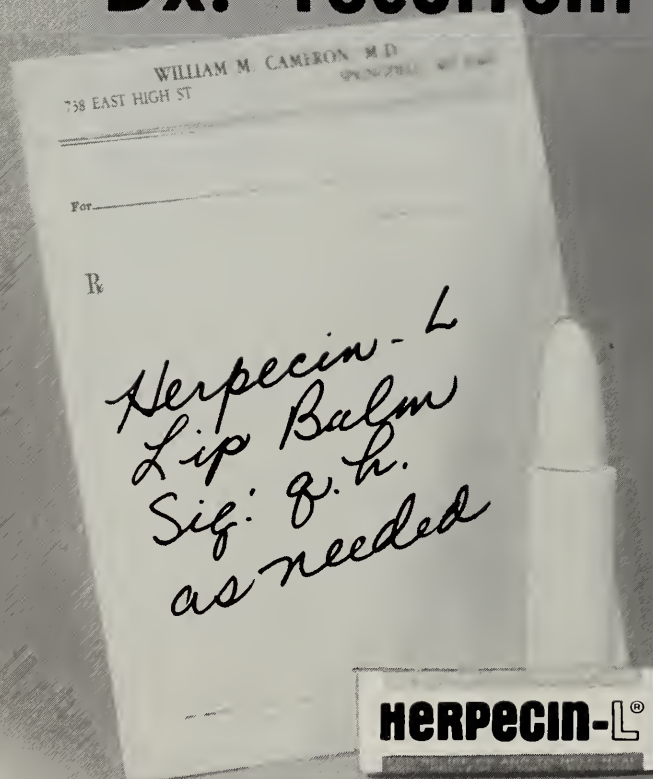
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AND ADMINISTRATORS**

September 26-28, 1985
The Hotel Inter-Continental
Hilton Head Island

The project has applied for Continuing Education (CME) Category I AMA Physicians Award for physicians attending the program.

SEPTEMBER 26, 1985

4:30 p.m. Registration

7:00 p.m. Social Hour

SEPTEMBER 27, 1985

8:00 a.m. Registration and Continental Breakfast

8:30 a.m. Call to Order

W.H. "Ham" Hudson, Co-Chairman—SCHA/SCMA Joint Project Steering Committee

Welcome

J. Lawrence Dozier, Jr., Chairman—South Carolina Hospital Association

Leonard Douglas, M.D., President—South Carolina Medical Association

Heyward Dantzler, Chairman—South Carolina Association of Hospital Governing Boards

8:45 a.m. WHERE DOES THE HEALTHCARE SYSTEM OF TOMORROW FIND YOU?

Perry Lambird, M.D., Pathologist

Medical Arts Laboratory—Oklahoma City, OK

9:45 a.m. Refreshment Break

10:00 a.m. IMPLEMENTING NEW BUSINESS VENTURES

John Abendshien, Principal

Dennis Meulemans, Manager

Charles Francis, Supervisor

Ernst & Whinney—Chicago, IL

12:00 noon Adjournment

12:30 p.m. Golf Tournament Begins

1:00 p.m. Tennis Tournament Begins

7:00 p.m. Social Hour

SEPTEMBER 28, 1985

8:00 a.m. Continental Breakfast

8:30 a.m. Call to Order

Richard Bright, M.D., Co-Chairman—SCHA/SCMA Joint Project Steering Committee

8:35 a.m. THE IMPACT OF MEDICAL MALPRACTICE

G. Dewey Oxner, Jr., Attorney at Law

Haynsworth, Perry, Bryant, Marion & Johnstone—Greenville, SC

9:35 a.m. Refreshment Break

9:50 a.m. MEDIA'S ROLE IN REPORTING THE DELIVERY OF HEALTHCARE

Dave Partridge, Public Relations Director

Greenville Hospital System—Greenville, SC

Barbara Chapman, Media Director/Freelance Healthcare Journalist

National Center for Missing and Exploited Children—Washington, DC

Allan Hoffman, Executive Producer/Medical Reporter

WLOS-TV—Asheville, NC

10:50 a.m. THE "NEW" EMPHASIS ON QUALITY ASSURANCE

W. Keith Sloan, M.D., Physician Surveyor—Hospital Accreditation Program

Joint Commission on the Accreditation of Hospitals—Chicago, IL

11:50 a.m. Closing Remarks

12:00 noon Adjournment

REGISTRATION FEES for the program are \$95 per person and include the cost of the program and all materials, two continental breakfasts, two social hours, and refreshment breaks. Spouse/Guest tickets may be purchased for the social hours and breakfasts at a cost of \$5 per social hour per person and \$5 per breakfast per person.

ROOM RESERVATIONS must be made no later than August 25 in order to receive the special conference rate, which is \$80 per room, single or double occupancy. Because the room block includes 200 rooms, we cannot guarantee rooms at The Hotel Inter-Continental at the special rate for more than the first 200 registrants.

GOLF AND TENNIS TOURNAMENTS are planned for Friday afternoon for all registrants wishing to participate. Golf fees are \$35 per person, and tennis fees are \$15 per person.

FOR MORE DETAILED PROGRAM INFORMATION AND REGISTRATION/RESERVATION FORMS, contact Linda Haines or Doris Clevenger at the South Carolina Hospital Association, 803/796-3080 or Bill Mahon at the South Carolina Medical Association at 803/798-6207.

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SCMA ANNUAL MEETING: 1985



Charles S. Bryan, M.D., presents the Thomas A. and Shirley W. Roe Award to J. Stewart Haskin, Jr., M.D., and Edward L. Hay, M.D.



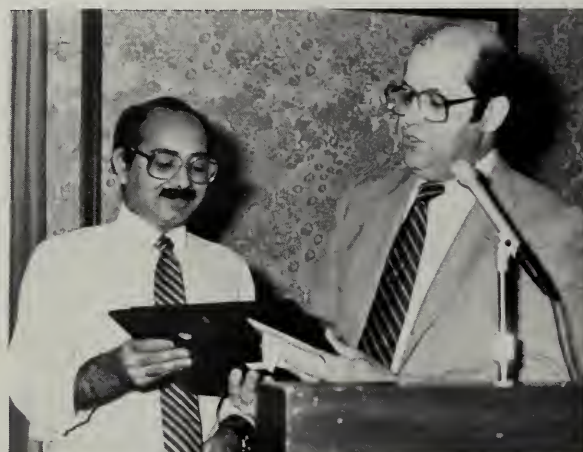
J. O'Neal Humphries, M.D., with AMA-ERF check presented to the USC School of Medicine by Mrs. Madge Littlejohn.



James J. Kilpatrick speaks at SOCPAC luncheon.



James Edwards, President, MUSC, with AMA-ERF check presented by Mrs. Madge Littlejohn.



Mobashir Salahuddin, Health Affairs Writer for *The State* newspaper, receives journalism award from Charles R. Duncan, Jr., M.D.

PICTORIAL HIGHLIGHTS



Leonard W. Douglas, Jr., M.D., being sworn in as the 121st President of the SCMA. Mrs. Douglas holds the Bible and Charles R. Duncan, Jr., M.D., administers the oath of office.



C. Tucker Weston, M.D., receives the President's Award for 1985 from outgoing President Kenneth N. Owens, M.D.



John J. Coury, M.D., Chairman of the AMA Board of Trustees, addresses the SCMA House of Delegates.



Kenneth N. Owens, M.D., receives outgoing President's Plaque from Chairman of the Board of Trustees Charles R. Duncan, Jr., M.D.



Donald G. Kilgore, Jr., M.D., is presented the A. H. Robins' Physician's Award for Community Service by Kenneth N. Owens, M.D.

SCMA AUXILIARY



Billie Brady at the podium, Drake Hotel, on Wednesday morning as outgoing President of the AMA Auxiliary.



AMA Auxiliary Convention Pages. *Front:* Pat Duncan, Nellie Claire Brown, Mary Anne Douglas, Sandra Smoak, Billie Brady. *Back:* Sara Shingler, Elise Cain, Mary Ivester.



Gavin Appleby, SCMA President-Elect, Billie, and Leonard Douglas, SCMA President, at a party for the S. C. delegation to the AMA hosted by Billie and Wayne Brady.



Leonard Douglas presents a gold "Doctors Bag" charm to Billie Brady at the House of Delegates meeting Wednesday morning.



Skippy Adkins, Mary Anne Douglas and Sara Shingler look on as Billie opens the "Doctors Bag" after closing ceremonies.

PICTORIAL HIGHLIGHTS: AMAA MEETING



Sheila Davis, AMAA Membership Committee, presents membership awards to Susanne Black, SCMAA President-Elect.



Mary Anne Douglas, Pat Duncan and Linda Smith, SCMAA Immediate Past President.



Madge Littlejohn and Kathy Figus with the "Pecan Tree." (Idea conceived by Linda Smith as part of a membership challenge.)



John Hawk, reelected to the AMA Constitution and Bylaws Committee and Billie Brady.



Billie with Marjorie Stands, SCMAA Treasurer and Pat Pulaski, SCMAA Vice President at a reception for the AMAA Board hosted by S. C.

President's Page



COMPONENT SOCIETIES — A VITAL LINK

This month, I began visitations to various county societies and medical staffs throughout the state. It is vitally important to organized medicine in South Carolina that leadership maintain a dialogue with its constituency at the grass roots level. Many physicians have little or no contact with the South Carolina Medical Association except through our mailings. If a physician does not serve on a committee or attend the SCMA Annual Meeting, there is little opportunity to be heard or become more familiar with what his or her association is doing.

One opportunity afforded you is through visitations from SCMA officers. Many county societies have responded to my offer to visit and to bring you up to date on SCMA activities, as well as to hear your comments and suggestions for future directions. All of this will make for a stronger association. I encourage all of your groups to contact SCMA Headquarters and arrange a visit.

Our Chief Executive Officer, Bill Mahon, will attend many, if not all of these meetings. Together we will attempt to address your concerns, as well as to tell you those of the SCMA. So gather your thoughts and questions and bring them to our meetings. Some county society officers have requested certain subjects they want addressed, and this is very good and just the type of input we need. If the SCMA is not addressing its members' needs or the needs of our patients and the public, we need to hear this.

Frequently your suggestions may bring about a change in SCMA policy. In this fast-changing health care industry, we must be able to adapt in a reasonable fashion. Recently your Executive Committee requested that we look again at our stated policy concerning alternate health care delivery systems. A discussion was brought about by the continued proliferation of HMOs and HMO/IPAs in the state. Our present policy is that each individual area has its own specific needs, and that the SCMA is willing to assist in any way possible for each area of the state. If we should be doing more, or moving in a different direction, then we should do so. This is just one example which comes to mind.

In the coming weeks, you will also be having requests for visits from Susie Nickles, our Director of Health Policy Affairs. She is available to assist you in your legislative and political action activities, so please utilize her expertise.

I look forward to seeing many of you in the coming weeks and months. The duty of SCMA officers and staff is to serve the medical profession and ultimately the patients we, in turn, serve. Please call on us.

Sincerely,

A handwritten signature in cursive script that reads "Leonard".

LEONARD W. DOUGLAS, M.D.
President



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INFORMATION FOR AUTHORS

Authors should refer to the detailed instructions in the January issue. Manuscripts and other correspondence should be addressed: The Editor, JOURNAL OF THE SOUTH CAROLINA MEDICAL ASSOCIATION, Post Office Box 11188, Columbia, S. C. 29211.

All manuscripts should be accompanied by a transmittal letter with the following paragraph: "This original work has not been submitted or published elsewhere, in entirety or in part. I (we) hereby transfer, assign, or otherwise convey all copyright ownership to the South Carolina Medical Association in the event that this work is published by the SCMA."

We request that manuscripts be concise (no longer than 8 typewritten pages, double-spaced), with no more than ten references. These should be cited in the text in superscript, e.g., "Bottsford, et al.³¹", and should conform to the following style: "3. Bottsford JE, Bearden RC, Bottsford JG: A ten year community hospital experience with abdominal aorta aneurysms. *J S C Med Assoc* 79: 57-62, 1983." Ordinarily, publication of four small illustrations or tables or the equivalent will be paid for by *The Journal*. Manuscripts should be submitted in duplicate. Reprints will be made available by the publisher.



THE JOURNAL

OF THE SOUTH CAROLINA MEDICAL ASSOCIATION

VOLUME 81

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NUMBER 9

MAMMOGRAPHY: WHY, WHEN AND HOW

E. Q. SEYMOUR, M.D.*

If appropriately used, is mammography a means of considerably reducing the death rate among women from breast cancer or a much publicized examination that will not make a meaningful impact on breast cancer mortality? Do benefits significantly exceed the risk of the radiation received as a result of the examination? Are other recently developed or refined methods of imaging the breast equally as effective or better than mammography for screening examinations of the breast for malignancies? Women are vitally concerned and deserve answers to these questions. Substantial data are now available that will allow appropriate conclusions to be drawn concerning the effectiveness of mammography as well as the benefits compared to risk.

In this presentation, mammography is used to denote the use of film or xeromammography.

DISCUSSION

Although radiological examination of the breast is not a new procedure, having been introduced by Salomon in 1913,¹ the quantity of radiation received during the study has been markedly reduced in the past decade. The radiation dose to the breasts has been decreased more than 90 percent when compared to mammograms done as recently as the early 1970's.^{2, 3} Image quality improvement has accompanied the reduced x-ray exposure received during the procedure. These

two factors now combine to offer a high rate of discovery of very small potentially curable breast cancers with a very slight risk of induced cancer using current low dose film or xeromammography.⁴ Studies in the United States have indicated that as much as a 35 to 40 percent reduction in mortality from breast cancer can be achieved when screening mammography is used according to current guidelines.^{2, 5, 6}

Although other types of breast imaging are now available, they are employed as supplementary procedures to mammography and are not recommended for breast screening. Ultrasound and diaphanography (light transmission examination of the breast) are both limited by an inability to detect small lesions and fine calcifications which are often the only sign of a malignancy.^{7, 8, 9} Thermography is not considered reliable in evaluating breasts and is not recommended.^{10, 11} Recently developed modalities such as computed tomography and magnetic resonance imaging may play a role in the future, but are not expected to be used in breast screening.^{7, 9, 12, 13}

During a large clinical trial in the United States in which 270,000 women underwent annual screening mammography as well as physical examination of the breast, over 90 percent of small (less than 1cm.) carcinomas discovered were detected by mammography whereas less than half of these were found by palpation.^{14, 15} Statistically, the majority of breast cancers measuring less than 1cm in size are confined to the breast and have a greater than 85 percent five year survival when

* Address correspondence to Dr. Seymour at the Department of Radiology, Medical University of South Carolina, 171 Ashley Avenue, Charleston, S. C. 29425.

compared to 47 percent if the tumors have already spread beyond the confines of the breast. The detection of minimal cancers localized to the breast is the primary purpose of mammographic screening. (Figure).

The false negative rate for mammography is reported to be between five and 10 percent.^{15, 16} Although mammography is a very accurate examination with a low false negative rate, the failure to confirm a suspicious clinical finding should not deter a biopsy. Mammography should always be closely coordinated with a palpatory examination.

When a small non-palpable lesion is detected by mammography, needle localization of the suspicious area prior to biopsy is recommended. After making appropriate measurements based on the mammograms, the radiologist inserts a 20 gauge needle containing a small guidewire into the breast. The tip is positioned in or in close proximity to the suspected malignancy. Topical or local anesthesia is used prior to introducing the needle. A repeat study with the needle in position is performed and if the location is satisfactory, the needle is withdrawn leaving a small hook guidewire in place.¹⁷ At operation, the surgeon follows the guidewire to its termination and removes the wire along with the tissue specimen which is sent for pathological examination.

High risk factors for the development of breast

cancers in women are (A) a mother or sister who had breast cancer, particularly before the age of 50; (B) prior personal history of breast cancer; (C) a previous breast biopsy showing atypical lobular or ductal hyperplasia.¹⁸ There are numerous other less significant factors which are reported to increase a woman's risk of developing a breast malignancy. Among these are included menopause beyond the age of 50, menarche before the age of 12, never married, first live birth after the age of 30 or no live births, and obesity.^{18, 19, 20} Many variables seem to act together in most women to determine relative risk for the development of breast cancer. One-third of women who develop breast cancer have no known risk factors and two-thirds have only one. No method has been found to isolate a small group of very high risk individuals.²⁰ Therefore, screening is recommended for all women above the age of 40.

The relationship between the type of breast pattern noted on a mammogram and the risk for future development of breast cancer has not been completely clarified. However, women beyond the age of 40 with dense dysplastic breast or those with a prominent ductal pattern are at higher risk than those with fatty type breasts.¹⁸

The American College of Radiology and the American Cancer Society now recommend a baseline mammogram between the ages of 35 and

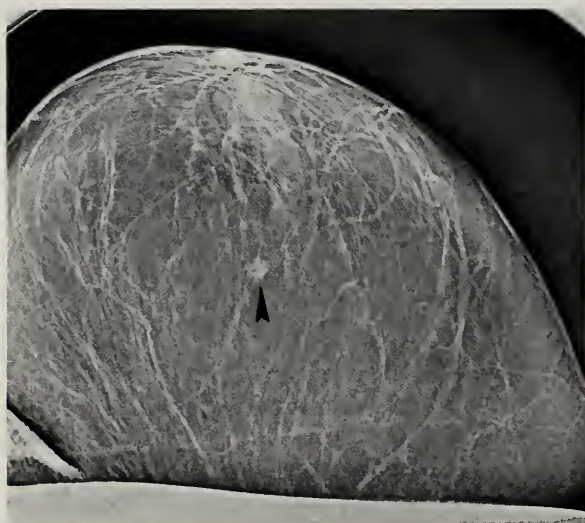


FIGURE 1a and b: A 5mm non-palpable carcinoma is noted in the central portion of the left breast (arrowhead). The lesion was confined to the breast with no lymph node involvement.

40 years. Annual or mammograms every other year are, depending upon risk factors, suggested between the ages of 40 and 49. Above age 50, annual mammograms are indicated.^{21, 22}

SUMMARY

The death rate from breast cancer has not changed significantly during the past 35 years.²³ When used according to current guidelines, film mammography or xeromammography can substantially (35 to 40 percent) reduce mortality due to breast cancer. Either method is equally effective and individual preferences determine the imaging modality that is used. Other methods of breast imaging are not recommended for screening, but may be used as adjunctive procedures. Physicians must know the appropriate use of mammography to achieve this decrease in deaths due to breast cancer. □

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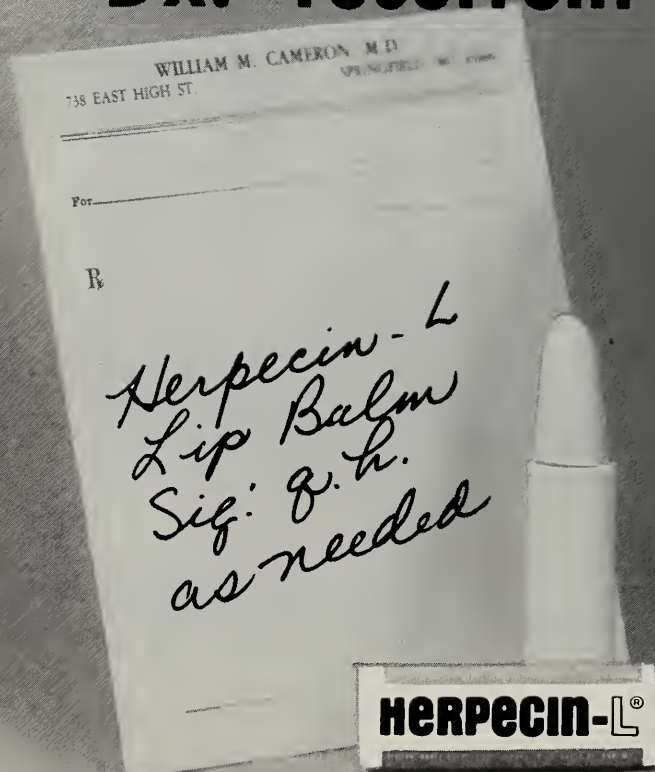
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A CLINICAL APPROACH TO AMENORRHEA

KAY F. MCFARLAND, M.D.*

Amenorrhea, as well as other menstrual disorders, are common during the female reproductive years. Although frequently physiologic, amenorrhea also may be secondary to hypothalamic, pituitary, ovarian, uterine, or outflow tract abnormalities. Therefore, a systematic plan is necessary to determine the cause of amenorrhea quickly and economically.

Menstruation, the cyclic growth and breakdown of the endometrium, normally occurs every 25 to 35 days and bleeding lasts two to eight days. Irregular, anovulatory cycles with long intervals between periods are so frequent, however, that menses must be absent for three months before the term amenorrhea is used. Amenorrhea is classified as "primary" if a woman has never menstruated and as "secondary" if there is cessation of menses in a woman who has previously menstruated.

Although the initial history may be focused somewhat differently depending on whether a woman has ever menstruated, the evaluation of primary and secondary amenorrhea is quite similar. Physiologic, then anatomic, and finally genetic and endocrine causes must be considered.

In primary amenorrhea, the focus is on the pattern and timing of sexual development which follows a fairly orderly sequence. Acceleration of growth is the first sign of increased hormonal production. Maximum linear growth usually precedes menarche by six months, with most girls growing five to nine centimeters during the year preceding the onset of menses. Breast buds and pubic hair are also early signs of increased estrogen secretion and sexual maturation.

Most girls will weigh ninety pounds or at least will be in the tenth weight percentile for their height when menses begin. Thin girls tend to begin menstruating later than heavy girls. Although there is a correlation between the age of menarche in mothers and daughters, the family

history does not significantly influence the evaluation which must be done for amenorrhea. The similar timing of puberty in mothers and daughters may be related more to weight patterns in families than to other genetic or inherited factors which affect the timing of menarche. A thorough history, careful physical examination, and evaluation of the growth chart may be all that are needed to reassure an adolescent under the age of sixteen that sexual development is occurring in a normal pattern.

The historical information which is most helpful in establishing the etiology of secondary amenorrhea relates to (1) the possibility of pregnancy, (2) the use of drugs which may induce amenorrhea, and (3) weight change which may lead to hypothalamic/pituitary dysfunction. In addition to the previous menstrual history and the type of birth control that is being used, early symptoms of pregnancy should be sought. For example, the exact date of the last menstrual period, the age of onset of menarche, the normal cycle length, and the duration and amount of flow should be recorded. Other aspects of the obstetrical history which may be important include whether a woman has ever had an abortion or curettage. The presence and duration of lactation also should be noted. Even in the absence of symptoms or physical signs which are suggestive of pregnancy, a serum pregnancy test is needed to exclude early pregnancy in any woman who presents with secondary amenorrhea.

Numerous drugs may produce amenorrhea. For example, the low estrogen containing oral contraceptives may not adequately stimulate endometrial growth, and amenorrhea may result. Phenothiazines, antihypertensive drugs, and birth control pills all may elevate prolactin levels and cause amenorrhea. Rarely, drugs used in cancer chemotherapy such as cyclophosphamide may cause gonadosuppression and amenorrhea.

In addition to pregnancy and drugs, weight loss or "thinness" is a common cause of secondary amenorrhea. Ballet dancers, marathon runners, gymnasts, and other athletes who have a relative low percent body fat frequently have delayed

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AMENORRHEA

onset of menarche or secondary amenorrhea. An increase in body weight and/or a decrease in exercise may be associated with return of menses.

To exclude other endocrine disorders which may result in amenorrhea, patients should be queried regarding a change in heat or cold tolerance, nails, skin, mental or physical "slowing up" (hypothyroidism), a change in the sense of smell (hypogonadotropic hypogonadism), swelling or fullness of the face (hypothyroidism, Cushing's disease), inability to concentrate (hypothyroidism), headaches (pituitary tumors), abdominal cramps (imperforate hymen), and hot flashes (menopause).

The history then is aimed primarily at excluding physiologic causes of amenorrhea or menstrual disorders related to drug use or weight loss. If none of these are found on the initial evaluation, then anatomic causes should be sought. These are relatively rare, and most can be excluded by simply visualizing the cervix on pelvic examination. In women with primary amenorrhea, the amount of endogenous estrogen secretion can be estimated by the degree of breast development, amount of pubic hair, and growth pattern. If breast development is far advanced, the subsequent evaluation of primary amenorrhea is identical to that of secondary amenorrhea.

However, if no breast development is present, the evaluation of secondary and primary amenorrhea is slightly different. See Charts 1 and 2. In women with primary amenorrhea, prolactin, T4, T3 uptake, and a lateral skull x-ray for sella size is usually done on the first visit. If these are normal, a karyotype and gonadotropin levels (FSH and LH) should be done. Usually based on these tests alone, a diagnosis can be established as indicated on the flow chart.

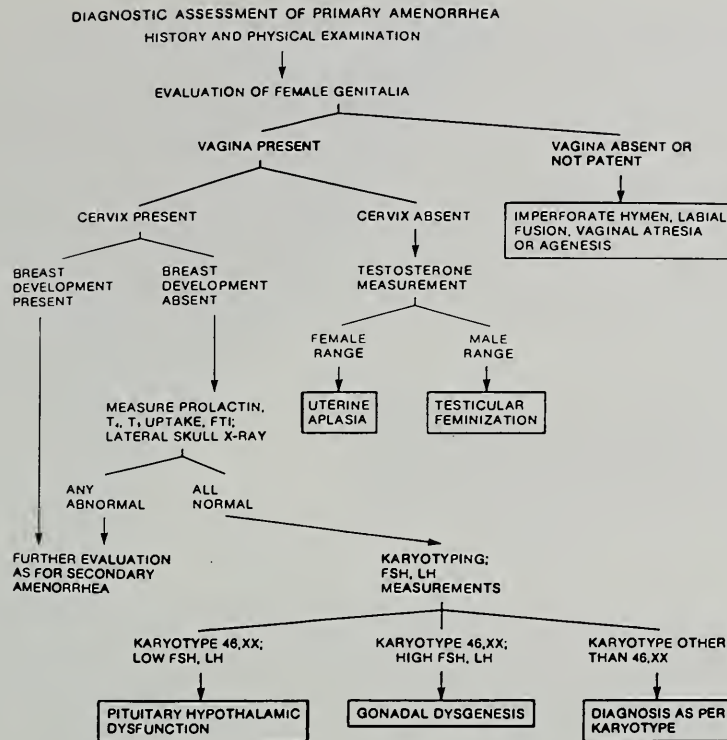
If the history and physical examination is unrevealing in women with secondary amenorrhea,

the major emphasis is on excluding early pregnancy. In addition to a serum pregnancy test, a T4, T3 uptake, prolactin level, and lateral skull for sella size should be ordered as in the evaluation of primary amenorrhea. For patients with a high prolactin level, a CT scan of the sella should be ordered to exclude a pituitary microadenoma. If the T3 uptake and T4 levels are low, hypothyroidism may account for the amenorrhea, and a TSH should be done to establish the etiology of hypothyroidism.

Also on the first visit, a five day course of progesterone may be prescribed. Bleeding usually occurs three to five days after stopping the progesterone. A positive withdrawal bleed indicates that endogenous estrogen levels are adequate to stimulate endometrial growth and that the problem is anovulation. However, if bleeding does not occur after progesterone alone, three or more weeks of estrogen followed by five days of estrogen plus progesterone therapy should be given. Bleeding after this combination indicates that the underlying problem is endogenous estrogen deficiency. FSH and LH levels should then be ordered. Low or normal levels should indicate pituitary hypothalamic dysfunction while high FSH/LH levels indicate estrogen deficiency related to ovarian failure.

In women with excess hair or virilism and amenorrhea, additional tests such as serum testosterone, 17-ketosteroids, and dexamethasone suppression tests may be needed to diagnose or exclude less common ovarian and adrenal disorders. However, the etiology of amenorrhea may be established in the majority of patients with a careful history, physical examination, and a very few tests (pregnancy test, prolactin, T4, T3 uptake, lateral skull x-ray, and a course of progesterone). □

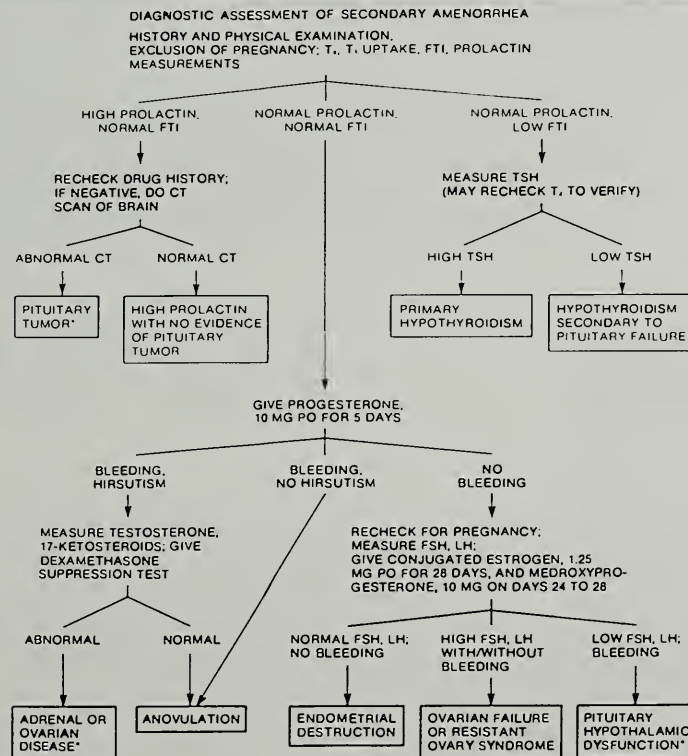
AMENORRHEA



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Taylor Robert: Difficult Diagnosis. Philadelphia, W.B. Saunders Company, pages 19 and 20, 1985.

CHART 1



*Further tests usually indicated

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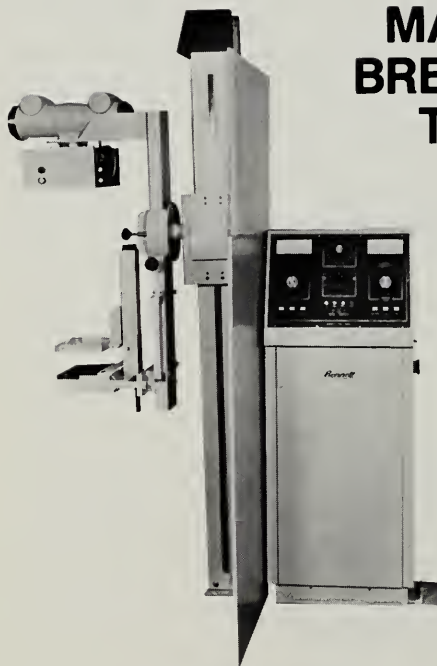
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SCMA

NEWSLETTER

September, 1985

**** !BULLETIN! ****

CALLED MEETING OF THE SCMA HOUSE OF DELEGATES

The SCMA House of Delegates is being called into special session by President Leonard W. Douglas, M. D., on Sunday, November 17, 1985 at 2:00 p.m. in Columbia. The purpose of the meeting is to consider a Resolution being developed by the SCMA Board of Trustees on the professional liability problem. Further details will be forthcoming, but Delegates should mark their calendars now.

Preliminary research at SCMA Headquarters indicates the last called meeting of the House of Delegates was in June, 1965 for the purpose of discussing physician participation in the Medicare program.

HAND IN HAND

Until recently, South Carolina was one of only a handful of states which did not bill for AMA dues. In April, the House of Delegates approved a recommendation to begin billing for the AMA in the 1986 membership year. These bills are scheduled to be mailed next month.

The medical profession needs strong representation through organizations which:

- * Speak up for physicians and patients.
- * Provide legislators, both nationally and statewide, with timely information.
- * Testify before government on issues affecting quality medical care.

Your county, state and national medical associations do these things for you daily. For instance, in the area of malpractice, the AMA has made this "one of its top priorities for this and the next decade." The South Carolina Medical Association is preparing a massive public and legislative campaign and the counties work hand in hand with both organizations to help insure a successful venture. This is only one of many medical issues that demand the cooperation of the three organizations working together. Your membership in all three is essential if we are to affect the great changes that will occur in medical care in the next decade. Medicine must have a strong unified voice. Please do your part and invest in the future of your profession. Every member is important.

In order to create the proper climate for our lobbyists, please join SOCPAC/AMPAC with a contribution -- it's the best long range program that ever has been devised to help elect qualified legislators who understand the health care needs of our state and nation.

Read Dr. Leonard Douglas' thoughts about membership on the "President's Page" in the October issue of *The Journal of the South Carolina Medical Association*.

WASHINGTON REPORT

The Department of Health and Human Services is continuing to violate the rights of Medicare Part B beneficiaries since it has failed to implement recommendations that would protect them against underpayments, the General Accounting Office says. In a new report to the Senate Aging Committee, the GAO called attention to the fact that the courts, since 1981, have directed HHS to establish mechanisms to give Part B beneficiaries added protection against Medicare underpayments. GAO says HHS had failed to do so because it would result in increased Medicare costs. The report said beneficiaries are being deprived of property without "due process of law."

The AMA will strongly protest new HCFA guidelines which would permit Medicare carriers to use "inherently reasonable" criteria in determining whether charges are reasonable. The manual change submitted to the Medicare carriers states that *"in some instances, the use of customary and prevailing charge data alone may lead to a result that it is not inherently reasonable for the purpose of reimbursing items and services furnished by physicians and other suppliers."* In such instances, HCFA advises, carriers may use "whatever relevant data are available...in order to calculate a reasonable charge" that accordingly would reduce the level of Medicare reimbursement.

Divergent views of what is "medically necessary" continue to cloud the question as to what is reimbursable to physicians for services provided to patients in Skilled Nursing Facilities (SNFs). A new communication from the HHS Inspector General to Medicare carriers asks them to withhold Medicare payments for SNF visits if there has been no change in a patient's condition on the basis that such visits are not "medically necessary." Present Federal and state laws require that Medicare patients in SNFs must be seen once every 30 days (some state laws say "once a month"). AMA's Washington Office staff is working with HHS staff in efforts to obtain resolution of the SNF reimbursement question that continues to confound physicians.

PANEL DISCUSSIONS ON MEDICAL ETHICS

Medical ethics will be the subject of three evening town meetings to be held November 12, 1985, February 4 and May 13, 1986 at USC's Longstreet Theatre in Columbia. Richland Memorial Hospital, in conjunction with the USC School of Medicine, the Columbia Medical Society, the Midlands Employers Health Council and Community Care, Inc., is sponsoring these public panel discussions. This project is part of a statewide effort called the "Carolinas Program on Medicine and Society," which was initiated and co-funded by the South Carolina Committee for the Humanities and The Duke Endowment.

The cost of medical care and the allocation of financial resources will be explored at the first meeting, November 12 at 7:30 p.m. The moderator will be Robert J. Burdett, Jr., an attorney with the Chicago law firm of Hinshaw, Culbertson, Mollman, Holson and Fuller.

For more information, contact the Public Relations Department at Richland Memorial Hospital, (803) 765-6891.

PHYSICIAN ATTESTATION

The AMA has supported a legislative proposal that would repeal the unpopular requirement for physician attestation of Medicare Hospital patient discharges.

In a letter to Senator Malcolm Wallop (R-Wyo), a member of the Energy and Natural Resources Committee and sponsor of the bill (S.988), James H. Sammons, M. D., Executive Vice President of the AMA, said the requirement *"is both unnecessary and inappropriate."* It *"does not change a physician's responsibilities to provide accurate information in the patient's record. With or without the attestation clause, physicians are still subject to penalties for fraudulent conduct and the attestation statement adds nothing substantive to modify these responsibilities."*

Equally unnecessary and inappropriate is the statement which physicians must have on file in hospitals indicating their acknowledgment of potential penalties for false statements in patients' records, Dr. Sammons noted. In introducing S. 988, Senator Wallop said the attestation requirement is *"basically a statement by physicians that they are not crooks. I cannot think of a more demeaning or arrogant exercise of bureaucratic power."*

IN MEMORIAM

Two former SCMA Presidents have passed away in recent weeks. The SCMA Board of Trustees and staff extend sincere sympathy to the families of Roderick Macdonald, M. D., and Robert Wilson, M. D.

Dr. Macdonald was President of the SCMA in 1950 and Dr. Wilson was President in 1964.

"LAND MINES OR GOLD MINES"

Representative Thomas M. Marchant III, Vice Chairman, National Conference of State Legislators' Health and Human Resources Committee, announced the Committee will hold a conference in Greenville in the Hyatt Regency Hotel, September 25-28, 1985. The conference theme is *"Land Mines or Gold Mines: Future Human Services Policy."*

Legislators from throughout the nation will be attending this meeting with prominent national, regional and state speakers presenting Health and Human Resource subjects as single speakers, point/counterpoint or panel formats. The subjects were chosen because of their impact on society and to State Legislators imposing solutions.

The private and public sector are encouraged to participate as the Health and Human Resource problems affect both, thus requiring increased knowledge and cooperation in determining solutions.

For registration information, contact Representative Marchant, P. O. Box 816, Greenville, SC 29602.

AMBULATORY SURGERY FACILITY LICENSING

Any physician or professional association wishing to build or license an ambulatory surgery facility should talk with the appropriate persons at DHEC. DHEC is responsible for certificate of need, building inspection, licensing standards and certification for third party reimbursement. Coordination with DHEC prior to expending any money will save owner's dollars and a great deal of frustration.

The following telephone numbers and persons are available for assistance:

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<i>Design & Construction</i>	<i>758-0366</i>	<i>Mr. Bob Chartier</i>
<i>Licensing</i>	<i>758-0360</i>	<i>Mr. Alan Samuels</i>
<i>Certification</i>	<i>758-0362</i>	<i>Mr. Xen Motsinger</i>

SEXUAL ASSAULT CONFERENCE

A conference on "Sexual Assault: Medical Issues Within the Legal System" will be held on October 26, 1985 from 10:00 a.m. to 4:00 p.m. at Houndslake Country Club in Aiken, S. C. The conference is sponsored by the Office of the Solicitor, Second Judicial Circuit for the purpose of examining the roles of the medical community in the area of sexual assault diagnosis and evidence collection, and encouraging coordination and communication among agencies and professionals dealing with child abuse and adult rape.

The Second Judicial Circuit Solicitor hopes that this one-day meeting will act as a model for other Circuits in South Carolina in introducing the new SLED evidence collection kit (see August, 1985 *Newsletter*) in providing a forum to discuss roles and problems, and in sharing local resources.

The Conference is offered FREE OF CHARGE to physicians practicing in Aiken, Barnwell and Bamberg Counties, nurses practicing in these areas who may have contact with victims, and emergency room personnel. Registration is open to others at a fee of \$15.00 which includes luncheon and materials. Registration is limited to the first 200 reservations.

For additional information, contact Margaret Key, (803) 649-3481, Extension 269.

DOUGLAS ENDORSED FOR AMA COUNCIL ON LEGISLATION

SCMA President, Leonard W. Douglas, M. D., has been nominated by the SCMA Board of Trustees for a position on the AMA Council on Legislation. Appointments to this Council are made by the AMA Board of Trustees. In a letter to the AMA Executive Vice President, SCMA Board Chairman Charles R. Duncan, Jr., M. D. said that "Because of his keen insight in the entire legislative arena, we sincerely recommend and unanimously support his candidacy - he would be an outstanding member of the AMA's Council on Legislation."

RELIEF OF SUPERIOR VENA CAVA SYNDROME WITH SPIRAL VEIN BYPASS GRAFTING*

JOE R. UTLEY, M.D.**

Superior vena cava obstruction due to carcinoma, lymphoma, or mediastinal fibrosis may produce severe symptoms of headache, fullness of the head and arms, shortness of breath, and feeling of suffocation. Bypass of the obstructed superior vena cava with a conduit fashioned from saphenous vein offers immediate relief of these symptoms. We recently employed spiral vein graft bypass of the superior vena cava in a patient with superior vena cava syndrome caused by bronchogenic carcinoma refractory to radiation therapy.

CASE REPORT

The patient is a 45-year-old lady who had right upper lobectomy for bronchoalveolar carcinoma of the lung four years previously. In June, 1984, she began to develop chest pain and shortness of breath. Chest x-ray showed a mediastinal mass. Mediastinoscopy was performed and biopsy showed a poorly differentiated carcinoma. The patient had 5,000 rad to the mediastinum in five weeks. Her shortness of breath increased and in February, 1985, she developed signs of superior vena cava obstruction. She had marked venous distention with edema, and cyanosis of the arms, head and neck. She had marked edema of the eyelids with suffusion of conjunctiva. She complained of constant, unremitting headache, fullness, choking, shortness of breath and feeling of suffocation. She also had difficulty swallowing. She had an additional 2,000 rads to the mediastinum in five days. Despite this additional radiation therapy, her symptoms continued. Venogram showed severe stenosis of the superior vena cava above the azygos vein. The operation was performed on March 1, 1985. A 25 cm segment of the left saphenous vein was excised and split longitudinally. The sheet of venous material was then

spiraled around a 36 chest tube and a conduit was fashioned from the spiral vein graft, according to the technique of Doty.^{1, 2} The left innominate vein was divided at its junction with the right innominate vein and the saphenous vein conduit was anastomosed end-to-end to the left innominate vein and to the right atrial appendage.

The patient had immediate relief of her superior vena cava syndrome. Within three days, the swelling was gone from her head and arms. She experienced immediate relief of the headache, dyspnea, choking, shortness of breath, and feeling of suffocation that she had experienced for several weeks.

DISCUSSION

Conduits fashioned from autogenous saphenous vein in a spiral fashion have been shown to have high rates of patency with palliation up to six years.^{1, 2}

Patients with the superior vena cava syndrome often receive excellent palliation from radiation therapy, especially with lymphoma or undifferentiated tumor. In patients with superior vena cava obstruction due to tumors that are not responsive to radiation therapy; in patients where radiation therapy has not been followed by a satisfactory response; and in patients with benign conditions obstructing the superior vena cava — spiral vein bypass grafting is an excellent therapeutic modality and results in excellent relief of symptoms and long-term patency.^{1, 2} Our experience with this patient suggests that this operation may be applied not only in patients with superior vena cava before radiation therapy, as suggested by Doty,^{1, 2} but also in patients in whom radiation results in inadequate relief of symptoms. The operation is confined to the thigh and the anterior mediastinum and was associated with very low morbidity in our patient.

As pointed out by Doty, bypass grafting from a single innominate or jugular vein to the right atrium results in bilateral relief of symptoms because of the flow through collaterals of the neck and the valveless jugular vein and cerebral venous

* From Spartanburg General Hospital, Spartanburg, S. C. 29303. Supported by the Cardiothoracic Research and Education Foundation.

** Address correspondence to Dr. Utley at 268 Connecticut Avenue, Spartanburg, S. C. 29302.

sinus.

ACKNOWLEDGEMENTS

The author is grateful to Drs. Henry G. Kelley, Jr., James D. Bearden, III, Eric Nelson, James E. Bradof, Charles M. Fogarty, and Wilson Smith for their assistance in the care of this patient. □

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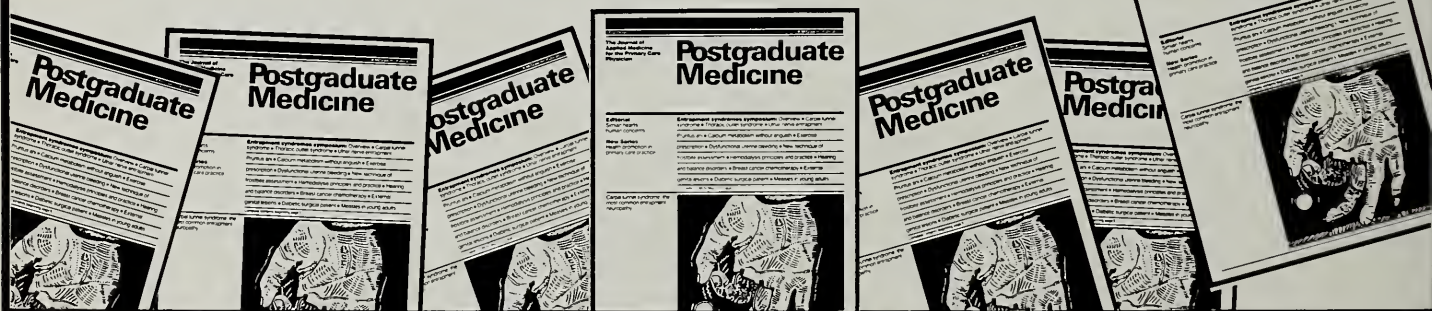
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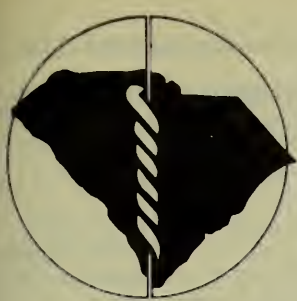
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SEPTEMBER

"SCIMER'S THIRD ANNUAL REVIEW AND UPDATE IN MEDICINE"

DATES: Sunday, September 22 - Friday, September 27, 1985

LOCATION: Mariner's Inn on Hilton Head Island, South Carolina

DESCRIPTION: The Third Annual Review and Update in Medicine is offering a multi-disciplinary program emphasizing primary care. This important conference will give participants an opportunity to acquire essential practice skills in carefully planned scientific sessions.

SPONSOR: South Carolina Institute for Medical Education and Research (SCIMER) of the South Carolina Medical Association

AUDIENCE: M.D.'s

FACULTY: Guest Lecturers

CREDIT: 26 hours, AMA Category I, CME Credit.* AAFP Prescribed for.

FEE: \$375.00

CONTACT: Barbara Jean Blanks, Post Office Box 11188, Columbia, S.C. 29211 (803) 798-6207

*The South Carolina Medical Association is accredited by the ACCME to offer programs in Continuing Medical Education that meet the requirements for Category I of the AMA Physician's Recognition Award.

THURSDAY-SATURDAY SEPTEMBER 26-28

HILTON HEAD ISLAND, InterContinental Hotel

"FIFTH ANNUAL CONFERENCE FOR TRUSTEES, PHYSICIANS AND ADMINISTRATORS"

SPONSOR: SCMA/SCHA

AUDIENCE: M.D.'s Hospital Trustees and Administrators

CONTACT: Linda Haines, Hospital Association, (803) 796-3080

FRIDAY-SATURDAY SEPTEMBER 27-28

CLEMSON, Ramada Inn

"CME 'Sym-PAWS-lum' 1985"

SPONSOR: Clemson and MUSC Physician Alumni

DESCRIPTION: Discussion concerning the diagnosis and treatment of current medical topics of interest to the general physician.

AUDIENCE: M.D.'s

CONTACT: R. Ramsey Mellette, M.D./Carole Smith (803) 792-4435

FEE: \$100

FACULTY: Guest and MUSC Faculty

CME CREDIT: 7 Hours AMA Category I, 7 Hours AAFP Prescribed, .7 CEUs

OCTOBER

SUNDAY-THURSDAY SEPTEMBER 15-19

ISLE OF PALMS, Wild Dunes

"SPORTS MEDICINE UPDATE 1985"

SPONSOR: MUSC

DESCRIPTION: Sports injuries diagnosis and management

AUDIENCE: Primary Care Physicians

CONTACT: Rosemarie Morwessel, M.D. (803) 792-3934

CME CREDIT: 21 1/4 Hours AAFP Prescribed

FRIDAY SEPTEMBER 20 2:30-4:30 P.M.

CHARLESTON, Charleston Sheraton at Lockwood Boulevard

"BREAST CANCER SYMPOSIUM"

SPONSOR: American Cancer Society and S.C. Oncology Society

DESCRIPTION: Topics covered include: "Surgical Management of Early Breast Cancer"; "Radiotherapy and Early Breast Cancer"; and "Adjuvant Chemotherapy and Early Breast Cancer".

AUDIENCE: Surgeons, Radiotherapists, Family Practice and Nurses

CONTACT: Lynne G. Bridges, Director Professional Education (803) 256-0245

FACULTY: Guest and Staff

THURSDAY-SATURDAY SEPTEMBER 19-21

CHARLESTON, Colony House

"Clinical Immunology Update For Primary Care Physicians"

SPONSOR: MUSC Department of Laboratory Medicine

DESCRIPTION: At the end of the course, the participants will be able to understand and discuss Basic Immunology Concepts

AUDIENCE: Primary Care Physicians

CONTACT: Mariano F. LaVia, M.D., (803) 792-3216

CME CREDIT: 14 Hours AAFP Prescribed

THURSDAY OCTOBER 3

COLUMBIA, Carolina Inn

"SEMINAR ON PREVENTION OF CHILD ABUSE AND NEGLECT"

SPONSOR: SCMA, S.C. Medical Association Auxiliary, S.C. Chapter Pediatrics and S.C. Chapter Family Practice.

DESCRIPTION: The program will include a discussion of legal issues of importance to physicians and a panel discussion. The panel will be made up of local experts in the field of child protection.

AUDIENCE: Physicians and Spouses and other interested parties.

FACULTY: Robert W. tenBensel, M.D., Professor, University of Minnesota

CONTACT: Donna Murphy, (803) 798-6207

FEE: \$25 Per Participant, \$15 Physician and Spouse, Interns and Residents

CME CREDIT: Available

THURSDAY-SATURDAY OCTOBER 24-26

HILTON HEAD ISLAND, Hyatt

"SC/NC Societies of Ophthalmology, 1985 Annual Scientific Session"

SPONSOR: SC/NC Ophthalmology Societies

AUDIENCE: Ophthalmologists

CONTACT: B.J. Blanks, (803) 798-6207

FACULTY: J. Lawton, M.D., George Waring, M.D. and Joseph Flanagan, M.D.

CME CREDIT: 6 Hours AMA Category I

THURSDAY-SATURDAY OCTOBER 10-12**COLUMBIA, Marriott Hotel
"HYPERTENSION UPDATE"**

SPONSOR: USC School of Medicine

DESCRIPTION: This course is designed for primary care health providers. It brings together noted authorities in the field of hypertension, who will present practical state of the art information.

AUDIENCE: M.D.'s, Nurses, Housestaff, Medical Students, Dieticians, Pharmacists, Social Workers, Volunteers and Patients

CONTACT: Steven J. Rosansky, M.D., (803) 776-4000, Ext 675

FEE: \$80 M.D.'s; \$45 Nurses, Dieticians, Social Workers, Pharmacists, Exhibitors, Volunteers, Residents; \$25 Students and Patients

FACULTY: Staff and Guest

CME CREDIT: 8.5 Hours AMA Category I, 8.5 Hours AAFP Prescribed, 7 Hours Contact

FRIDAY OCTOBER 11**CHARLESTON, Marriott Hotel
"COLORECTAL CANCER: ESSENTIALS FOR PRIMARY CARE PHYSICIANS"**

SPONSOR: American Cancer Society, S.C. Division, Inc.

DESCRIPTION: To elicit maximal involvement of surgeons, oncologists, gastroenterologists, primary care physicians and nurses in the evaluation of risk factors, early detection, diagnosis, management and follow-up of colorectal cancer through a convenient, concise and clinically relevant education program.

AUDIENCE: M.D.'s

CONTACT: Lynne Bridges, (803) 256-0245

FEE: \$25 M.D.'s, \$10 Students and Residents

FACULTY: Bernard M. Schuman, M.D., Medical College of GA

CME CREDITS: 6 Hours AMA Category I Applied For, 6 Hours AAFP Prescribed Requested

SATURDAY OCTOBER 19**CHARLESTON, Charleston Sheraton
"S.C. EPILEPSY ASSOCIATION ANNUAL MEETING"**

SPONSOR: S.C. Epilepsy Association

DESCRIPTION: Any interested people come to learn more about epilepsy

AUDIENCE: Anyone interested in epilepsy

CONTACT: Janie Goodwin, Columbia, (803) 799-8341; Sarah Gainey, Charleston, (803) 747-0319

FACULTY: Dr. John Pellock, University of VA
Dr. Braxton Wannamaker**FRIDAY-SUNDAY OCTOBER 25-27****HILTON HEAD ISLAND: Sea Pines Plantation
"VASCULAR AND PULMONARY DISEASES: DIAGNOSIS AND MANAGEMENT"**

SPONSOR: University of Colorado School of Medicine

AUDIENCE: M.D.'s

CONTACT: Medical Education Resources, Toll-free 1-800-421-3756

FEE: \$295 M.D.'s, \$190 Non-physicians

CME CREDIT: 13 Hours AMA Category I; 13 Hours AAFP Prescribed; 13 Hours PRA Category I; 13 Hours ACEP Category I

NOVEMBER

FRIDAY NOVEMBER 1**ANDERSON, Anderson Memorial Hospital
"CRITICAL CARE 1985"**

SPONSOR: Anderson Memorial Hospital and Carolina/Virginia Society of Critical Care Medicine/Upper Savannah AHEC

DESCRIPTION: The topics will be "Cerebral Resuscitation", "Rye's Syndrome", "Non-Cardiac Pulmonary Edema", "Croup and Epiglottitis", "Septic Shock" and "Different Diagnosis and Management of Oliguria"

AUDIENCE: M.D.'s

CONTACT: Frederic G. Jones, M.D., (803) 261-1109

CME CREDIT: 5 Hours AMA Category I

WEDNESDAY NOVEMBER 6**COLUMBIA, Sheraton Northwest I-20
"LIVING WITH EPILEPSY"**

SPONSOR: Richland Memorial Hospital/Neuro Nursing Department Midlands Epilepsy Association

DESCRIPTION: All day workshop for health care providers. Recent advances in the management of epilepsy and current research

AUDIENCE: M.D.'s, Nurses and all Health Care Providers

CONTACT: Pam Wells or Shirley Harkey, (803) 765-7406

FEE: \$35

FACULTY: Dr. J. Kiffin Penry; Dr. Braxton B. Wannamaker

CME CREDIT: Approved 6 Contact Hours

THURSDAY-SUNDAY NOVEMBER 7-10**CHARLESTON, Sheraton Hotel****"37th ANNUAL SCIENTIFIC ASSEMBLY OF THE SCAFP"**

SPONSOR: South Carolina Academy of Family Physicians

DESCRIPTION: To provide quality CME in specific areas of need

AUDIENCE: Primary Care Physicians

CONTACT: B.E. Nicholson, M.D., (803) 288-6647

CME CREDIT: 30 Hours AAFP Prescribed

THURSDAY & SATURDAY NOVEMBER 21-22**GREENVILLE, Holiday inn Haywood****"12th ANNUAL PIEDMONT PERINATAL SYMPOSIUM" —
"CURRENT TOPICS IN PERINATOLOGY"**

SPONSOR: Greenville Hospital System/Spartanburg General Hospital

DESCRIPTION: Lectures, workshops, panel discussion conducted by nationally known leaders in perinatology. With advances in field of perinatology occurring rapidly, there is a need to stay abreast of new developments and trends in the field.

AUDIENCE: M.D.'s, Nurses and other Perinatal Disciplines

CONTACT: David H. Wells, M.D., (803) 242-7939

FEE: \$100 for M.D.'s, \$45 Nurses

FACULTY: Guests and Staff

CME CREDIT: 11 Hours AMA Category I; 8 Hours AAFP Prescribed Requested; 12.6 Hours AHEC/American Nurses Association

FRIDAY-SUNDAY NOVEMBER 22-24**CHARLESTON, Sheraton Hotel****"CARE OF THE CRITICALLY ILL OR INJURED"**

SPONSOR: Division of Respiratory/Critical Care MUSC

DESCRIPTION: Rapid recognition of and practical approach to the management of each condition listed.

AUDIENCE: Primary Care Physicians

CONTACT: H. David Reines, M.D./Marian Cook, (803) 792-2346

FEE: \$170 M.D.'s, \$85 Residents and Allied Health Professionals

CME CREDIT: 18 Hours AMA Category I; 18 Hours AAFP Prescribed; 18 Hours ACEP Category I; 21 CE Credits-AANA

GRAND ROUNDS U.S.C. School of Medicine

2nd and 4th WEDNESDAYS 3:00-4:00**GASTROINTESTINAL RADIOLOGY CONFERENCE**

COLUMBIA, VA Radiology Dept. Conference IC 209, VA Hospital

SPONSOR: USC School of Medicine, Dept. of Radiology and Gastroenterology and Division of Internal Medicine

DESCRIPTION: One-half of the conference will be a discussion and film review of a specific subject. The second half will be devoted to current case material with both radiographic and endoscopic findings.

AUDIENCE: Radiologists, Gastroenterologist and other interested physicians

CONTACT: James J. Farrell, M.D., (803) 733-3295

FACULTY: USC School of Medicine, Dept. of Radiology; Division of Gastroenterology, Internal Medicine and Guest Speakers

CME CREDIT: 1 Hour AMA Category I per session

MONDAYS**7:00 A.M.****ORTHOPAEDIC GRAND ROUNDS**

COLUMBIA, Richland Memorial Hospital - 1st Floor

CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

MONDAYS**4:00 P.M.****BASIC SCIENCES SEMINAR SERIES**

CONTACT: Louis Terracio, Ph.D., (803) 733-3373

MONDAYS-THURSDAYS 12:00-1:00 P.M.**INTERNAL MEDICINE LECTURE SERIES**

Richland Memorial Hospital 7 West Classroom

CONTACT: J. O'Neal Humphries, M.D., (803) 765-6563

2st & 3rd MONDAYS**12:30 P.M.****G.I. JOURNAL CLUB**

Dorn Veteans' Hospital Room 5A127

CONTACT: John Orchard, M.D., (803) 776-4000 Ext. 673

MONDAYS, TUESDAYS, WEDNESDAYS, & THURSDAYS**12:00-1:00 P.M.****FAMILY PRACTICE CONFERENCE**

COLUMBIA, Richland Memorial Hospital, Large Dining Room of the Cafeteria—Mondays—Family Practice Conference Room—Tuesdays and Thursdays

SPONSOR: Dept. of Family Practice, USC School of Medicine
AUDIENCE: Family Practice and Internal Medicine Physicians and Medical Students

CONTACT: Roslyn D. Taylor, M.D., (803) 765-6118, Dept. of Family Medicine Richland Memorial Hospital, Columbia, SC

FACULTY: Dept. of Family Medicine and Internal Medicine, USC School of Medicine

CME CREDIT: 1 Hour AMA Category I per session

TUESDAYS 7:00 A.M.**BASIC SCIENCE & PATHOLOGY ASPECTS OF ORTHOPAEDICS**

Richland Memorial Hospital - Radiation Therapy Conference Room

CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

**2nd & 4th TUESDAYS 12:00 NOON
PATHOLOGY G.I. CONFERENCE**

Dorn Veterans' Hospital, Room 1A172

CONTACT: John Orchard, M.D., (803) 776-4000, Ext. 673

3rd TUESDAYS 12:30 P.M.**OB/GYN GRAND ROUNDS**

COLUMBIA, Richland Memorial Hospital

SPONSOR: USC Dept. of OB/GYN, RMH, MUSC, Spartanburg and Greenville

DESCRIPTION: One of a series of live interactive broadcasts over the HCN, a statewide closed circuit TV network for CME in OB/GYN.

CONTACT: Ronald B. Wade, M.D., (803) 765-7156

FEE: None

CME CREDIT: 1 Hour AMA Category I (per session)

FRIDAYS 8:00 A.M.**PEDIATRIC GRAND ROUNDS**

COLUMBIA, Richland Memorial Hospital

SPONSOR: USC School of Medicine, Dept. of Pediatrics

CONTACT: Warren Derrick, M.D., (803) 765-7211

CME CREDIT: 1 Hour AMA Category I (per session)

WEDNESDAY 12:00 NOON**PSYCHIATRY GRAND ROUNDS**

Hall Institute Form

CONTACT: Bonnie Ramsey, M.D., (803) 758-8052

CME CREDIT: 1 Hour AMA Category I (per session)

2nd & 4th WEDNESDAYS 12:00 NOON**PULMONARY MEDICINE CHEST CONFERENCE**

Richland Memorial Hospital, 7th Floor Conference Room

1st & 3rd THURSDAYS 12:00 NOON

3rd Floor Conference Room, Dorn Veterans' Hospital

CONTACT: Gerald N. Olsen, M.D., (803) 733-3112

WEDNESDAYS 6:00 P.M.**ORTHOPAEDICS PROBLEM CONFERENCE**

Richland Memorial Hospital Conference Room "P", ACC II

CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

THURSDAYS 10:00 A.M.**HEMATOLOGY/ONCOLOGY GRAND ROUNDS**

Dorn Veterans' Hospital, 5-West Classroom

CONTACT: George P. Satiano, M.D., (803) 733-3112

4th THURSDAY 12:00 NOON**G.I. RESIDENTS CONFERENCE**

Dorn Veterans' Hospital, 4th Floor Conference Room

CONTACT: John Orchard, M.D., (803) 776-4000, Ext. 673

1st THURSDAYS 4:00 P.M.**RADIOLOGY DEPT. CONTINUING EDUCATION CONFERENCE**

USC School of Medicine Library Bldg., Room B-116

CONTACT: David F. Adcock, M.D., (803) 733-3295

CME CREDIT: 1 Hour AMA Category I

THURSDAYS 4:00 P.M.**ENDOCRINE CASE PRESENTATION**

USC School of Medicine Administration Bldg. 2nd Floor Conference Room

CONTACT: Juraj Osterman, M.D., (803) 733-3112

FRIDAYS 7:00 A.M.**ORTHOPAEDIC SUB-SPECIALTY TOPICS**

Richland Memorial Hospital - Large Private Dining Room

CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

FRIDAYS 9:00-11:30 A.M.**PREVENTIVE MEDICINE GRAND ROUNDS**

USC School of Medicine Library Bldg. Room 327

CONTACT: Alan Chovil, M.D., (803) 733-3306

CME CREDIT: 2 Hours AMA Category I

FRIDAYS 1:00 P.M.**INTERNAL MEDICINE GRAND ROUNDS**

COLUMBIA, Richland Memorial Hospital Auditorium

SPONSOR: Dept. of Medicine, USC School of Medicine

AUDIENCE: Internal Medicine and Family Practices Physicians

CONTACT: J. O'Neal Humphries, M.D., Chairman, Dept. of Medicine, (803) 765-6563

CME CREDIT: 1 Hour AMA Category I

SATURDAYS 9:00-10:00 A.M.**SURGICAL GRAND ROUNDS**

COLUMBIA, Richland Memorial Hospital Auditorium

SPONSOR: USC School of Medicine, Dept. of Surgery

DESCRIPTION: Lectures and case presentations given by the department staff and guest speakers

AUDIENCE: Faculty, Residents, Students and Private Clinicians

CONTACT: Carl H. Almond, M.D., (803) 254-4158; James L. Haynes, M.D., (803) 765-7452; Frederick L. Greene, M.D., (803) 776-4000, Ext. 582

FACULTY: Staff of Dept. of Surgery and guest lecturers

CME CREDIT: 1 Hour AMA Category I (per session)

GRAND ROUNDS

Medical University of South Carolina

MONDAYS 9:30 A.M.**PATHOLOGY - Surgical Pathology Conference**

CONTACT: Drs. Betsill, Garvin, and Metcalf, (803) 792-3821

EACH MONDAY 12:00 NOON**UROLOGY - Clinical Sciences Bldg. Suite 644**

CONTACT: Dr. Stepheyn N. Rous, (803) 792-4531

MONDAYS 12:30-1:30 P.M.**RADIOLOGY - Noon Conference**

CONTACT: Dr. E.Q. Seymour, (803) 792-4261

MONDAYS 4:00-5:00 P.M.**RADIOLOGY - Special Imaging Conference**

CONTACT: Dr. E.Q. Seymour, (803) 792-4261

EVERY OTHER MONDAY 10:00 A.M.-12:00 NOON**PATHOLOGY - Pathology Microscopic Round Table Conference**

CONTACT: Dr. Gordon Hennigar, (803) 792-3121

MONDAY-FRIDAY**RADIOLOGY - Visiting Radiologist**

CONTACT: Dr. E.Q. Seymour, (803) 792-4261

TUESDAYS 7:00 A.M.**SURGERY - Cancer Conference/Surgical Grand Rounds**

CONTACT: Drs. Anderson and O'Brien, (803) 792-3361 or 3276

TUESDAYS 7:00-8:00 A.M.**ORTHOPAEDIC SURGERY - Orthopaedic Grand Rounds**

CONTACT: Dr. John B. McGinty, (803) 792-3934

TUESDAYS 8:00-10:00 A.M.**PATHOLOGY - Seminar-Tutorial Group Sessions, Systemic Path.**

CONTACT: Dr. Jane Upshur and Dr. Gordon Hennigar, (803) 792-2456

TUESDAYS 8:30-9:30 A.M.**OB/GYN - Morning Conference**

CONTACT: Dr. Peter Van Dorsten, (803) 792-2684

TUESDAYS 9:00-10:00 A.M.**MEDICINE - Medical Grand Rounds**

CONTACT: Dr. Jon J. Levine and Dr. James Allen, (803) 792-2528

TUESDAYS 11:00 A.M.-Noon
LABORATORY MEDICINE - Laboratory Medicine Case Presentation
CONTACT: Elena Prevost, (803) 792-3937

TUESDAYS 11:00 A.M.-NOON
PSYCHIATRY - Departmental Grand Rounds
CONTACT: Dr. R.R. Mellette, Jr., (803) 792-4037

TUESDAYS 12:30-1:30 P.M.
OB/GYN - TV Grand Rounds
CONTACT: Julia Day, Division of Continuing Education, (803) 792-4435

TUESDAYS 1:00-2:00 P.M.
PATHOLOGY - OB/GYN Pathology
CONTACT: Dr. John Metcalf, (803) 792-4050

TUESDAYS 2:00-3:00 P.M.
PSYCHIATRY - Case Conference
CONTACT: Dr. Thomas Steele, (803) 792-4050

TUESDAYS 4:00-5:00 P.M.
PATHOLOGY - Orthopaedic Pathology Conference
CONTACT: Dr. A.J. Gavin, (803) 724-2258, Ext. 2260

TUESDAYS 4:00-5:00 P.M.
SURGERY - Surgical Seminar Series
CONTACT: Dr. Max S. Rittenbury, (803) 792-3251

1st & 3rd TUESDAYS 4:00-5:00 P.M.
PATHOLOGY - Gastrointestinal Pathology Conference
CONTACT: Dr. Francis M. Brown, (803) 577-5011, Ext. 566

2nd & 4th TUESDAYS 1:30-3:00 P.M.
PSYCHIATRY - Case Conference/VA
CONTACT: Dr. James D. Sexauer, (803) 577-5011, Ext. 234

2nd & 4th TUESDAYS 4:00-5:00 P.M.
PATHOLOGY - Renal Conference
CONTACT: Dr. Sterling K. Ainsworth, (803) 792-4171

WEDNESDAYS 9:00-10:00 A.M.
PATHOLOGY - Graduate Medical Education in Pathology
CONTACT: Dr. Gordon Hennigar, (803) 792-3121

WEDNESDAYS 12:10-1:10 P.M.
FAMILY MEDICINE - Family Medicine Noon Conference Series
CONTACT: Dr. Ben Goodman, (803) 792-2411

WEDNESDAYS 1:00-2:00 P.M.
LABORATORY MEDICINE - Clinical Pathology Conference/VA
CONTACT: Dr. Jerome L. Sullivan, (803) 577-5011, Ext. 466.

WEDNESDAYS 3:00-4:00 P.M.
LABORATORY MEDICINE - Hematology Conference
CONTACT: Rebecca E. Reynolds, MT(ASCP)SH, (803) 792-2933

WEDNESDAYS 3:00-4:00 P.M.
PATHOLOGY - Charleston Veterans Administration Medical Center
Tumor Board
CONTACT: Dr. Helen M. Dodds, (803) 577-5011, Ext. 466.

WEDNESDAYS 6:00-7:00 P.M.
RADIOLOGY - Low Country Ultrasound Society
CONTACT: Dr. Stephen I. Schabel, (803) 792-4261

WEDNESDAYS 7:30-8:30 P.M.
OB/GYN - Monthly Journal Club Meeting
CONTACT: Dr. Oliver Williamson, (803) 792-2864

Last WEDNESDAY of the month 9:00-11:00 A.M.
PATHOLOGY - Grand Rounds
CONTACT: Dr. J.D. Balentine, (803) 792-3581

THURSDAYS 8:30-10:00 A.M.
PSYCHIATRY - Medicine Teaching Case Conference, Consult/
Liaison Service
CONTACT: Dr. Oliver Bjorksten, (803) 792-2971

THURSDAYS 8:30-9:30 A.M.
PATHOLOGY - Surgical Pathology Conference
CONTACT: Drs. Betsill, Garvin and Metcalf, (803) 792-3821

THURSDAYS 8:30-10:00 A.M.
PSYCHIATRY - Psychiatry Youth Conference
CONTACT: Dr. Donald J. Carek, (803) 792-3051

THURSDAYS 8:30-9:30 A.M.
RADIOLOGY - Teaching Conference in Neuroradiology
CONTACT: Dr. Paul Ross, (803) 792-4267

THURSDAYS 9:30-10:30 A.M.
NEUROSURGERY - Neurosurgery Clinical Conference
CONTACT: Dr. P. Perot, (803) 792-2421

THURSDAYS 9:30-10:30 A.M.
SOCIAL WORK - Pediatric Burn Team Meeting
CONTACT: Elena Bell, (803) 792-3846

THURSDAYS 10:30-11:30 A.M.
NEUROLOGY - Neurology Grand Rounds
CONTACT: Dr. Edward L. Hogan, (803) 792-3221

THURSDAYS 10:30-11:45 A.M.
NEUROSURGERY - Neurosurgery Lecture
CONTACT: Dr. P. Perot, (803) 792-2421

THURSDAYS 12:10-1:10 P.M.
FAMILY MEDICINE - Family Medicine Grand Rounds
CONTACT: Dr. Ben Goodman, (803) 792-2411

THURSDAYS 1:00-2:00 P.M.
PATHOLOGY & DERMATOLOGY - Dermatopathology Conference
CONTACT: Dr. John C. Maize, (803) 792-5858

THURSDAYS 4:00-5:00 P.M.
SURGERY - Junior House Officer Conference
CONTACT: Dr. Marion C. Anderson, (803) 792-3961

1st or 2nd THURSDAYS 11:45-12:45 P.M.
PATHOLOGY - Neuropathology Conference
CONTACT: Dr. J. Douglas Balentine, (803) 792-3581

2nd, 4th & 5th THURSDAYS NOON
FAMILY MEDICINE - Noon Conference
CONTACT: Dr. Ben Goodman, (803) 792-2411

MONTHLY 2:30-3:30 P.M.
LABORATORY MEDICINE - Immunohematology Journal Club
CONTACT: Margaret J. Simmons, MT(ASCP) and Mary A. Spivey, MT
(ASCP)SBB, (803) 792-2671

FRIDAYS 8:30-10:00 A.M.
MEDICINE/ENDOCRINOLOGY - Endocrinology Journal Club/
Endocrinology Research Conference
CONTACT: Dr. Maria F. Lopes-Virella, (803) 792-2528

FRIDAYS 8:30-9:30 A.M.
PATHOLOGY - Surgical Pathology Conference
CONTACT: Drs. Betsill, Garvin, and Metcalf, (803) 792-3821

FRIDAYS 8:30-9:30 A.M.
PEDIATRIC - Pediatric Grand Rounds/Case Conferences
CONTACT: Dr. Milton Westphal (803) 792-2113 and Dr. Ashby Taylor,
(803) 792-3291

FRIDAYS 10:00-11:30 A.M.
PSYCHIATRY - Teaching Case Conference, Adult Inpatient
CONTACT: Dr. Gordon Trockman, (803) 792-3051

FRIDAYS 12:00-1:00 P.M.
PATHOLOGY - Clinico-Pathologic Conference
CONTACT: Dr. R.A. Harley, (803) 792-4444

FRIDAYS 12:10-1:10 P.M.
FAMILY MEDICINE - Noon Conference Series
CONTACT: Dr. Ben Goodman, (803) 792-2411

FRIDAYS 1:00-2:00 P.M.
LABORATORY MEDICINE - Clinical Microbiology Conference
CONTACT: Dr. John Manos, (803) 792-2984

FRIDAYS 4:00-5:00 P.M.
SURGERY - Surgical Services Conference
CONTACT: Dr. Marion C. Anderson, (803) 792-3961

FRIDAYS 4:00-5:30 P.M.
MEDICINE/ENDOCRINOLOGY - Endocrinology Case Conference
CONTACT: Dr. J.A. Colwell, (803) 792-2528

SATURDAYS 9:00-10:00 A.M.
SURGERY - Cancer Conference
CONTACT: Dr. Paul O'Brien, (803) 792-3276

SATURDAYS 10:00-11:00 A.M.
SURGERY - Surgical Grand Rounds
CONTACT: Dr. Marion C. Anderson, (803) 792-3961

BRONCHOGENIC CARCINOMA PRESENTING AS BENIGN ESOPHAGEAL DISEASE*

DARRYL S. WEIMAN, M.D.**

FREDERICK L. GREENE, M.D.

T. J. BUNT, M.D.

CARL H. ALMOND, M.D.

Benign tumors of the esophagus are rare compared to their malignant counterparts. Some patients with bronchogenic carcinoma may present with a chief complaint of dysphagia and have a barium swallow consistent with benign esophageal disease. Careful evaluation can often reveal the primary malignancy in these patients so as to avoid unnecessary surgery.

We report a case of recurrent lung carcinoma that presented as primary esophageal disease. Only after surgical excision were we able to confirm the bronchogenic nature of the tumor.

CASE REPORT

A 58-year-old black male underwent a right upper lobectomy for a lung nodule in 1981, and was found to have a Stage I adenocarcinoma of the lung. The patient did well after that operation except for chest wall pain at the site of his thoracotomy incision. Worsening of that pain led his primary physicians to recommend palliative radiotherapy to his ribs although they had no documentation that his pain was due to metastatic disease. In April of 1983, he received 3000 rads in 10 fractions to the right anterior lower ribs and the same dose to the right posterior mid rib cage (the area that was symptomatic to palpation). His chest wall pain persisted unrelieved by multiple medications. He was referred for psychiatric consultation where the diagnosis of depression was made and maprotiline hydrochloride was started with improvement of his symptoms.

The patient did well until he developed dysphagia, upper abdominal pain and hemoptysis in September 1984. On September 11, 1984 he underwent flexible bronchoscopy which showed no

endobronchial lesions, and no source of the hemoptysis. Biopsies of the scarred area of the right upper lobe stump were obtained and showed fibrosis of bronchial submucosal glands. An upper GI study was obtained and showed a smooth filling defect in the mid-esophagus (Figure 1). Comparing the study to an UGI obtained in November 1983 showed the filling defect to be present and unchanged (Figure 2).

Esophagogastroduodenoscopy was done which showed a smooth indentation on the right lateral wall of the esophagus at 32 cm. from the incisors. The mucosa was normal and the aortic arch was at 28 cm. No biopsies were done. Computerized



FIGURE 1. Barium swallow from September 1984 showing the filling defect in the mid-esophagus.

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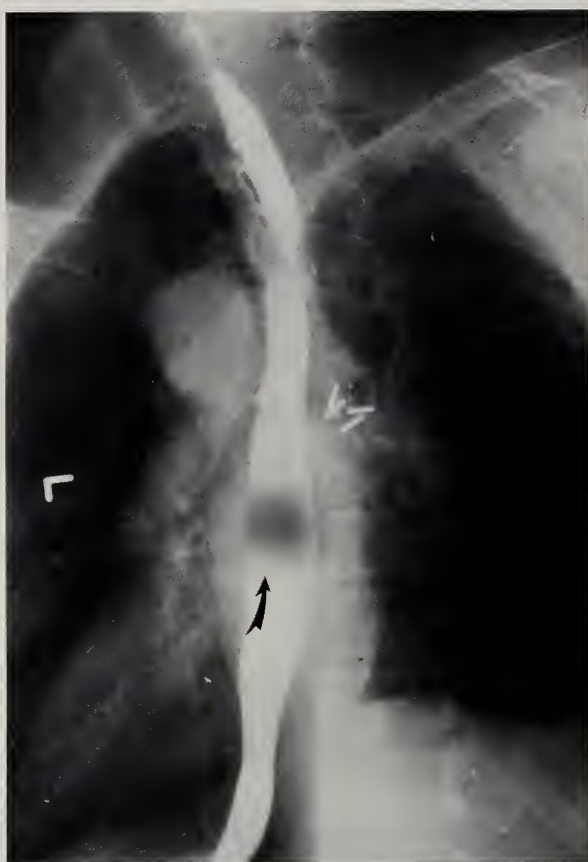


FIGURE 2. Barium swallow from November 1983 showing the filling defect in the mid-esophagus.

tomographic (CT) scan of the chest and upper abdomen showed no evidence of metastatic or recurrent lung carcinoma. A presumptive diagnosis of leiomyoma of the esophagus was made.

On September 21, 1984, through a right thoracotomy incision, a smooth submucosal mass measuring 3.5 cm., grey black in color, was removed from the submucosa of the esophagus. A biopsy of an irregular feeling area of the right lower lobe was also obtained.

Pathological evaluation revealed recurrent adenocarcinoma of the lung with metastasis to the esophagus.

The patient had a good postoperative course with complete relief of his dysphagia and upper abdominal pain. Further palliative radiotherapy to the right lung and mediastinum is planned.

DISCUSSION

Benign tumors of the esophagus make up less than one percent of esophageal neoplasms. The clinical presentation usually includes dysphagia

and chest pain. These patients can also present with upper GI bleeding or obstructive breathing.¹

In 1981, Hansen et al. reported on six cases of bronchogenic carcinoma that presented as primary esophageal disease.² They stressed the need for thorough evaluation of these patients to identify the primary pulmonary malignancy so as to avoid unnecessary surgery on the esophagus. Since the majority of the esophageal findings are subcarinal, they recommend that bronchoscopy be done in all of these patients.

Toreson reported an autopsy series where esophageal involvement with other primary cancers occurred in 3.2 percent of cases.⁶ Their most common primaries were lung and breast cancers, although any neoplasm that metastasizes to the mediastinum can present with esophageal symptoms. In 1980, Anderson and Harell reported on fifteen cases of secondary esophageal tumors.⁴ In their series the primary sites were lung (7), breast (4), hypernephroma (1), pancreas (1), cervix (1), and bladder (1).

The primary bronchogenic nature of our patient's disease was not identified by preoperative evaluation which included bronchoscopy with biopsies, esophagoscopy and CT scan of chest and upper abdomen. It is curious that the mass had persisted unchanged for 10 months as documented by successive UGI's. Resection of the mass allowed us to make the diagnosis and relieved him of his primary symptom of dysphagia.

We recommend thoracotomy and resection for those patients who present with esophageal symptomatology whose preoperative evaluation fails to delineate the nature of their disease. If a benign esophageal tumor is found, appropriate resection may be undertaken; even if a metastatic lesion is encountered, local resection will afford both a diagnosis to direct further care, and allow excellent palliation of the presenting symptoms.

SUMMARY

A case of recurrent bronchogenic carcinoma is reported that masqueraded as a primary benign esophageal tumor. Extensive preoperative evaluation failed to reveal the true nature of the tumor and led to exploratory thoracotomy for excision of a presumed submucosal leiomyoma. Histologic study of the excised specimen confirmed the true metastatic diagnosis. □

BILIARY DYSKINESIA; DIAGNOSIS BY COMMON BILE DUCT MANOMETRY AND TREATMENT BY ENDOSCOPIC SPHINCTEROTOMY*

JOHN L. ORCHARD, M.D.**

CHARLES A. BICKERSTAFF, M.D.

PATRICK BRADY, M.D.***

Patients with biliary pain, abnormal liver function tests, and a dilated common bile duct (CBD) after cholecystectomy are thought to have the postcholecystectomy syndrome. As manometry of the biliary tract has become more available, it is apparent that a subgroup of patients with the postcholecystectomy syndrome have sphincter of Oddi (SO) dysfunction, i.e., biliary dyskinesia, and can be treated successfully by endoscopic sphincterotomy.¹ We report on a patient with postcholecystectomy syndrome and SO dysfunction who was treated successfully by endoscopic sphincterotomy. The current state of our knowledge on biliary dyskinesia is also reviewed.

CASE REPORT

A 58-year-old man was seen for bloating and vague postprandial discomfort. An oral cholecystogram revealed multiple radiolucent filling defects in the gallbladder consistent with gallstones. Cholecystectomy and common bile duct exploration were done on November 12, 1983. Seven days postoperatively, a T-tube cholangiogram showed several small (2-4 mm) stones in the distal CBD. The T-tube was removed on January 11, 1983, after a repeat T-tube cholangiogram was normal.

He did well until about January 1984, when he began complaining of recurrent episodes of severe cramping right upper quadrant and epigastric pain usually after meals. Physical examination and liver function tests were repeatedly normal.

The pain became increasingly frequent and severe. He would not eat anywhere except at home for fear of developing abdominal pain. Endoscopic retrograde cholangiopancreatography (ERCP) on August 28, 1984 showed narrowing of the distal CBD, but no dilatation or stones (Fig. 1). Injection of the radiocontrast medium into the CBD reproduced his abdominal pain.

Since the patient's symptoms suggested presumptive SO dysfunction, he underwent manometry of the CBD and SO on October 23, 1984. Following intravenous Diazepam and topical Cetacaine spray to the oral pharynx, the Olympus GIF-1T10 duodenoscope was passed into the second portion of the duodenum where the ampulla

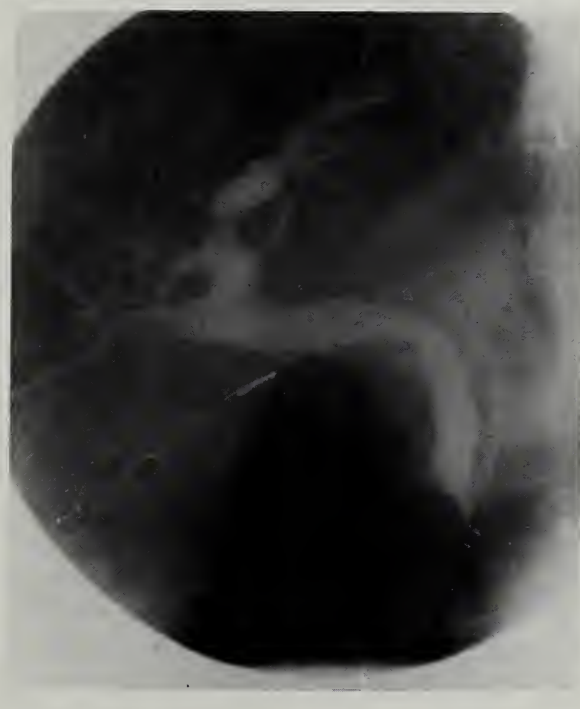


FIGURE 1. Radiograph from ERCP showing minimal narrowing of the distal common bile duct but no apparent dilatation.

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of Vater was identified. A triple-lumen polyethylene biliary manometric probe (Arndorfer Medical Specialties, Greendale, Wis.) was passed through the endoscope and into the CBD. Injection of three ml of 60 percent Hypaque showed the catheter to be in the CBD. Each lumen of the catheter was infused with water at a rate of .3 ml per minute by a Harvard pump (Milling, MA). Pressure changes were recorded by volume displacement transducers (Gould Statham, Oxnard, CA) connected to a six-channel physiological recorder (Electronics for Medicine, Clearwater, FL). Following a five-minute period of stabilization, the catheter was withdrawn in 1-2 mm increments, recording for 30 to 60 seconds at each station. Ductal pressure, basal SO pressure, SO phasic contractions, and common bile duct-duodenum gradient were measured. Measurements were expressed relative to intraduodenal pressure, which was arbitrarily defined as zero.

Common bile duct pressure averaged 18 mmHg and basal SO pressure was 40 mmHg (Normal \cong 20 mmHg). SO phasic contractions as high as 190 mmHg were observed. Because our experience with biliary tract manometry was limited, the patient was referred to the Tampa Veterans' Hospital where results of repeat biliary tract manometry using a catheter perfused with a hydraulic infusion pump were essentially identical to our measurements.

Because of the patient's severe symptoms, following informed consent, endoscopic sphincterotomy was performed using an American Endoscopy spincterotome with a blended cutting-coagulating current. The patient had immediate relief of his recurrent episodes of postprandial abdominal pain. He remains asymptomatic at the time of this writing. Liver function tests are normal.

DISCUSSION

Recurrent episodes of biliary pain and transient elevations of liver function tests may occur following cholecystectomy and are said to be part of the spectrum of the so-called postcholecystectomy syndrome.² These patients may have stenosis of the distal CBD and dilatation of the CBD on radiographic biliary visualization, i.e., ERCP or percutaneous transhepatic cholangiography. As more experience is gained with biliary manometry, it is becoming apparent that a subgroup of patients with the postcholecystectomy syndrome

do not have a fixed fibrous stenosis of the CBD, but have a motor disorder of the biliary drainage system.

It has previously been difficult to distinguish between patients with a fixed fibrous stenosis of the distal CBD and patients with a functional narrowing of the distal CBD, i.e., spasm of the SO. Recent adaptations in manometric recording techniques now allow accurate evaluation of the CBD and SO.⁴ A normal pressure profile of the distal biliary drainage system is beginning to emerge which allows abnormalities to be identified.^{5, 6} The normal pressure in the CBD is about 10 mmHg greater than intraduodenal pressure. Pressure in the SO is 5-10 mmHg greater than CBD pressure and phasic, high pressure contractions (\cong 80 mmHg) occur within the SO at a rate of four to six per minute.

At least three groups of investigators have reported on patients with the postcholecystectomy syndrome who have elevation of the SO pressure.^{7, 8, 9} Although a consensus does not exist regarding treatment of these patients, this subgroup of patients seems to have resolution of their signs and symptoms following endoscopic sphincterotomy.¹ Greenen et al reported on 45 patients who were postcholecystectomy and had recurrent unexplained biliary-like pain plus one or two of the following criteria: CBD dilatation, delayed emptying of contrast at ERCP, or recurrent liver function test abnormalities.¹ Biliary tract manometry was performed on all patients who were then randomized to endoscopic sphincterotomy or sham endoscopic sphincterotomy. At 12 months follow-up, 91 percent of patients who had an elevated SO pressure had striking benefit from



FIGURE 2. Sphincter of Oddi Manometry. The middle line depicts measured pressure in the sphincter of Oddi as the manometric catheter is withdrawn from the common bile duct. The straight lines represent intraduodenal pressure (bottom) and pressure in the common bile duct (top). The reference pressure (zero) is different for the three pressure tracings.

BILARY DYSKINESIA

endoscopic sphincterotomy compared to only 45 percent of patients with normal SO pressure. They concluded that biliary tract manometry was useful to evaluate and identify patients with presumptive SO dysfunction and that patients with elevated SO pressure seemed to benefit from endoscopic sphincterotomy. Siegal has also reported similar, although non-randomized, results following endoscopic sphincterotomy treatment of patients with elevated SO pressure and the postcholecystectomy syndrome.¹⁰

Patients who have elevated SO pressure post-cholecystectomy are also reported to have additional abnormalities of biliary tract motor function. Abnormally rapid phasic contractions of the SO compared to healthy controls have been described.¹¹ Also, a higher proportion of retrograde compared to antegrade peristalsis in the sphincter has been reported in patients with elevated SO pressure⁷ and in patients with CBD stones¹² compared to normal controls.

The technique of biliary tract manometry seems to be useful to identify a subgroup of patients with the post-cholecystectomy syndrome and elevated SO pressure. This subgroup of patients reportedly can be treated effectively by endoscopic sphincterotomy. The patient reported here supports this contention. □

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MEETING ANNOUNCEMENT

South Carolina/North Carolina Societies of Ophthalmology, 1985 Annual Scientific Session

Faculty: J. Lawton Smith, M.D.,
George Waring, M.D., and
Joseph Flanagan, M.D.

Meeting Site: The Hyatt on Hilton
Head Island, South Carolina

Meeting Dates: Thursday, October
24 - Saturday, October 26, 1985

Credit: AMA Category I, 6 Hours

*For More Information Contact:
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Vol. 5, Issue No. 9

September 1985

WHAT YOU SHOULD KNOW BEFORE YOU BUY STOCK

Successful investing requires more than good luck.

Last month I discussed "how you should begin" the process of investing in the stock market. This month, I will discuss the different types of stocks and other general factors involved in the selection process.

Making your Selection.

An investor is generally defined as someone who is willing to take a moderate risk for a moderate investment return. In contrast, a speculator is a person willing to take substantially greater risks for the potential of higher profits in the future. Which one are you?

The following is a brief description of the different types of stock available and their different objectives. The kind that appeals to you will depend on your own needs and goals.

Income Stocks.

Best suited for conservative investors, these stocks primarily focus on providing current income (dividend payments) and safety of principal, as opposed to future growth. The investor who's in need of income to meet current needs. (i.e., a retiree) will generally favor income stocks, as these securities pay a higher than average return. Utility and mature industrial stocks are two examples of income stocks.

Growth Stocks.

For the investor willing to accept some risk (and a lower dividend) in return for potential capital appreciation, growth stocks may be the answer. Growth companies, rather than paying high dividends, reinvest a good part of their earnings right back into the company with the aim of expanding and creating future earnings increases. Within the broad category of "growth stocks" exists a wide range of stocks suited to investors with differing objectives. However, in general, growth stock investors have one thing in common: a desire for capital appreciation.

Speculative Stocks.

Speculative issues include: newly formed companies, small companies that have just gone public, turnaround situations, highly leveraged companies, etc. Of course, these companies offer substantial appreciation potential, but they also entail greater than normal risk.

The Particulars.

Let's say you've analyzed your objectives and decided upon the general type of stock you're interested in -- the one that best meets your personal needs and goals. Now it's time to get down to specifics.

Choosing a company to invest in can be a complex and personal decision. The first step is to choose the industry in which you'd like to invest. You may choose to invest in a particular industry because of your own expertise in an area. Or, you may know that companies in a certain industry generally offer stocks suited to your personal objectives. For example, utility stocks, with their steady dividends, are generally suited to income-oriented investors. In contrast, a newly formed or high glamour company is bound to offer appealing growth opportunities but also entail greater than normal risk.

It's also important to look at the economy to see if it favors your chosen industry. With an eye toward diversification, you'll want to select the industries that appear healthiest in today's economy and, moreover, those which hold potential for the future. After all, you wouldn't want to be the investor who owns only energy stocks at a time when oil prices continue to fall around the world. On the other hand, if OPEC were to suddenly devise a price-saving strategy that could lead to an industry turnaround, you wouldn't want to miss out, either.

There's a whole world of professionals out there -- an entire industry -- making their living just helping you decide how to make the right stock selection; the one that makes the most sense in today's economic environment. Seeking such professional assistance can help you steer your way toward profitable opportunities.

However, there is also a tremendous variety of investment- and economy-related materials you can investigate on your own. You can check various investment publications; materials made available by investment services like Standard & Poor's and Moody's; even the financial pages of your local newspaper to determine an industry's relative well being in today's market environment.

Regardless of how you make your decision, the next step is to zero in on a particular company within that industry -- and analyze it carefully. A company's characteristics -- its sales and earnings record and its dividend policy -- can provide the necessary insight into your company's future outlook. It's all a matter of getting down to fundamentals.

FURTHER INFORMATION

If you would like to receive further information on any of the topics covered in this newsletter, please write to Martin Lefkowitz, CFP, E.F. Hutton & Company, Inc. 2700 Middleburg Drive, Suite 200, Columbia, SC 29204; or Call (800) 922-1112.

* * * * *

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Editorial

THE PRESIDENT'S POLYP

Overnight, "polyp" became a household word. Reporters explained the nature of the lesion with great clarity. The public was told that there are 130,000 new cases of colorectal cancer each year, with a present cure rate of 44 percent but with a potential cure rate of 75 percent. The patient's positive attitude encouraged everyone that — yes — cancer can be cured and that a large measure of optimism helps.

All of this is good. However, it seems surprising that public education was necessary at all. For years — both individually and connectively — our profession has sought to inform the laity about the nature of colorectal cancer and about its early diagnosis. Have we failed to get our message across?

My informal survey among lay friends indicated that most of them already knew about polyps, but that they had obtained this information from experience, not from schooling. Consistently over the years, spokespersons for organized medicine have pleaded that education in such matters should begin early — in the public schools. "Polyp," like "plaque," should be a part of everyone's vocabulary by the time of graduation from high school. Education in physicians' offices should not be primary but rather reinforcing or remedial.

The President's experience as reported by the press made me feel rather virtuous — for three reasons.

I feel outrageously virtuous to recall having celebrated my 41st birthday by scheduling an appointment with a friendly proctologist for fiberoptic colonoscopy. And I check my stool for occult blood at least three times a year.

Second, I take pride in the role that *The Journal* has taken in disseminating basic information regarding early detection of colorectal and other cancers. Our record over the past 18 months suggests a commitment by South Carolina physicians to the cause of early detection of colorectal cancer which I find to be, quite frankly, outstanding.

Last year's volume began with a splendid study from Spartanburg, by Drs. Louis F. Knoepp, Jr.

and G. Steven Suits, comparing the efficacy of barium enema and colonoscopy in the diagnosis of colon and rectal cancers.¹ And concluding that volume, on the next-to-the-last page, one finds that we provided a full-page notice for a symposium on "Colorectal Cancer: Update '85" which was held in Columbia on January 11.

In the June issue of the current volume, a study from the Department of Family Medicine at the Medical University of South Carolina emphasized the value of training family practice residents in fiberoptic sigmoidoscopy.² The entire July issue consisted of a proctology symposium, edited by Dr. Leon Banov, Jr., of Charleston. This symposium featured two excellent articles by Dr. Knoepp on screening procedures for colon cancer.³⁻⁴ Scheduled for October, the second part of the proctology symposium will feature yet another excellent paper by Dr. Knoepp on "Management of Polyps of the Colon and Rectum." I especially like Dr. Knoepp's work because it illustrates the value of tabulating and publishing data obtained from private practice — something *The Journal* strongly encourages. Finally, the December issue will feature another review article on fiberoptic sigmoidoscopy by Dr. Frederick Greene of Columbia, again emphasizing the valuable role of this procedure in the office detection of colorectal cancer.

Thus, this year's volume features papers with practical advice about early detection of colorectal cancer from all three geographic regions of South Carolina — lowcountry, midlands, and upcountry!

Finally, we should all feel virtuous in the nature of what we do. It has been said that medicine is the only profession that constantly seeks to find ways to abolish its necessity. Unlike the clergy and the law — both of which have codified guarantees of their continued *raison d'être* — the nature of medical research is to seek ways to prevent disease. There is perhaps no better illustration than our constant efforts to prevent cancer. Listening to the radio one morning prior to the President's surgery, I recall being impressed by a message on

behalf of a Columbia hospital by Dr. James White. Dr. White described new procedures for voice restoration following surgery for carcinoma of the larynx (procedures for which Dr. White would be reimbursed) — but in the next breath, he described the far greater benefits to be derived from stopping smoking (for which Dr. White would not be reimbursed).

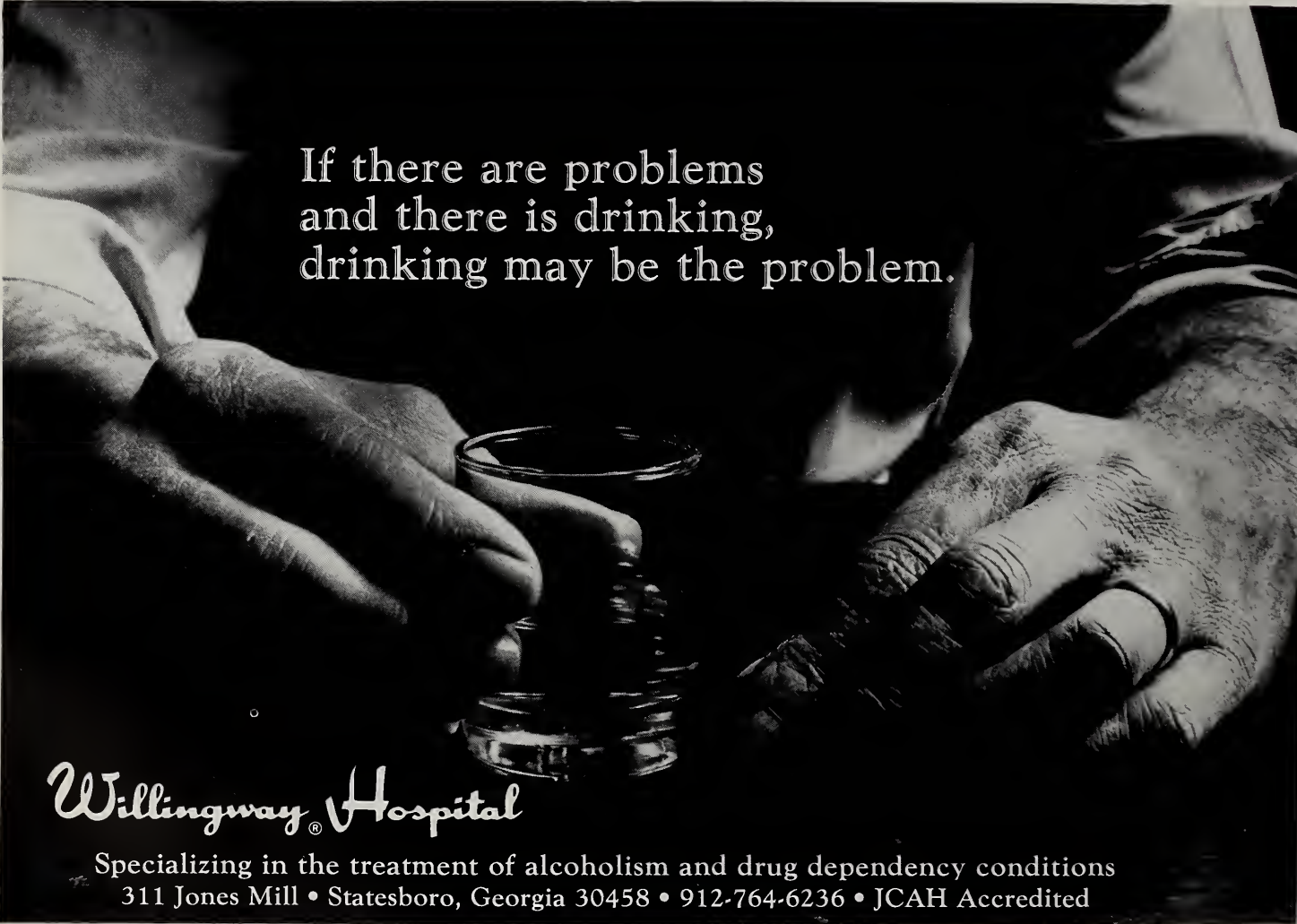
The public should also be aware that preventive medicine, therapeutic medicine, is a constantly-evolving discipline. Although our recommendation may at times appear to be rather arbitrary, they emanate from a rather complex and deliberate process consisting of epidemiologic surveillance, clinical research, and thoughtful reflection. That the president's polyp involved the cecum dramatically illustrated these complexities. The recently-appreciated left-to-right shift

in the distribution of colorectal carcinomas decreases the reassurance value of unrevealing digital and sigmoidoscopic examinations. Thus, the public should realize that even basic issues such as the use of tests for occult blood, barium enemas, and endoscopic procedures for early cancer detection are subject to our constant, ongoing scrutiny.⁵

— CSB

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ON THE COVER: JAMES EVANS, M.D., 1831-1909 ENGINEER, PHYSICIAN, SCHOLAR AND SERVANT

When James Evans, born September 12, 1831, in Marion, South Carolina, enrolled in The Citadel at Charleston, he could not have known of the varied life that lay before him. Finishing The Citadel in the class of 1853 as a civil engineer, James Evans applied for a position with the Cheraw and Darlington Railroad Company. This early engineering training allowed him to attract the attention of General Tilghman, who was building the New Orleans and Mississippi Railway. During this time, James Evans gained the attention of the Governor of Arkansas and in 1857 was placed in charge of the building of the great levees along the Mississippi and Arkansas Rivers. During his tenure as engineer, Mr. Evans contracted malaria and yellow fever on several occasions. Surviving these attacks, his health was much impaired and his own personal physician advised him to give up the engineering profession and leave the area.

At this time in his life he had become somewhat enamoured of the medical sciences and thus enrolled in the University of Pennsylvania in 1859, taking his Medical Degree in 1861. His technique of study was interesting. He attached himself to well-known physicians at the time and would spend months and months studying an organ's system. For example, it is reported that he spent three months listening only to healthy lungs, followed by three months of study of diseased lungs. This technique of study was applied to the other organ systems of the body. At the end of his formal training, as many other Southerners, he elected to take finishing training in the hospitals of Paris, London and Berlin. As he was nearing the time for departure, the *Charleston Mercury* reported the opening shots of the Confederate War when South Carolinian troops from his own college, The Cit-

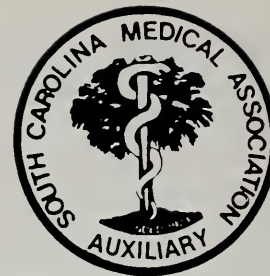
adel, fired on the merchant ship supplying Fort Sumter. Recognizing that this meant "WAR," Dr. Evans returned to his native South Carolina and volunteered for service in the Confederacy. He was appointed as Regimental Surgeon and performed his services throughout the war. After Appomattox, Dr. Evans returned and settled in Marion County.

As a servant of his profession, he not only practiced medicine with great recognition and appreciation, he served in many elected capacities in organized medicine. He was President of the state medical association in 1890. Following his term of service, he was appointed by the Governor to the State Board of Health and, in 1895, was appointed its administrative officer. It was under his influence that many of the laws for the development and classification of vital statistics now presently used in South Carolina were instituted. He was untiring in his effort to gain stricter laws enforcing sanitation and the regulation of infectious and contagious diseases. This interest led him to the publication of many papers, some of which were "Typhoid Fever," "Diphtheria," "Consumption and Method of Prevention," and "Cholera." His "Public Health Work in South Carolina" was so well done that it received the bronze medal at the Paris Exposition of 1900.

Following his active career, he retired in 1904 and realized a life dream of spending a winter in Rome with his family. Death came July 15, 1909, at Clifford Springs, New York. Dr. Evans would be proud to be remembered as a member of the United Confederate Veterans, the United Confederate Surgeons and South Carolina Chapter of the Sons of the American Revolution.

—THOMAS M. LELAND, M. D., Ph.D.

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ON THE COVER: LOUIS A. BUIE, M.D. 1890-1975

"I have asserted previously that I would gladly insert my finger into the rectum of a patient professionally, with whom I would not care to shake hands with socially" wrote Gus Buie, whose picture appears on the cover. Dr. Louis A. Buie was the most famous proctologist to have come from South Carolina.

Born in Kingstree, South Carolina, on July 30, 1890, Dr. Buie had two sisters and one brother. His parents, Mr. and Mrs. Wilson Buie, are buried in a Georgetown cemetery.

Dr. Buie received his Bachelor's Degree in 1911 from the University of South Carolina. There he made many friends. Among his friends were Thomas P. Stoney, former Mayor of Charleston, and James Mahoney, Charleston businessman, whom Dr. Buie invariably asked about when we would chat at national meetings.

In 1915, Dr. Buie received his Doctorate in Medicine from the University of Maryland. After internship in Maryland, he entered the Mayo Clinic as a Fellow in surgery and two years later transferred to the medicine service. During World War I, he served in the Army Medical Corps in Italy. Returning to the Mayo Clinic at the request of Dr. W. J. (Will) Mayo, Dr. Buie established the Section on Proctology.

Through his teachings and writing, Dr. Buie's prestige and influence developed. He became an international authority in proctology. He delivered lectures and wrote papers and books. The quoted sentence at the beginning of this article was lifted from his book, *Practical Proctology*, 1938. In the second edition of his work, I was pleased that he had cited studies on lymphogranuloma venereum carried out at the Medical University of South Carolina by Dr. Julius Goldberg and me.

"Dr. Buie was a founder of the American Board of Proctology in 1934, and later served as Secre-

tary and President. He was also President of the American Proctologic Society, the Minnesota State Medical Association, and the Zumbro Valley Medical Society, and was Chairman of the Section of Gastroenterology and Proctology of the American Medical Association. He was Secretary-Treasurer of the Advisory Board for Medical Specialties, a consultant to the U. S. Air Force Surgeon General's office, and a Delegate to the American Medical Association. In 1949, he was awarded an honorary degree of Doctor of Science by the University of South Carolina."

The above quote from "In Memoriam" to Dr. Buie appeared in *Diseases of the Colon and Rectum*, a journal he helped establish in 1957 and served as its Editor until 1967, when he became Editor Emeritus.

Dr. Buie's fame attracted many patients and he made many warm friends. At the 1958 meeting of the American Proctologic Society at the formal banquet, Dr. Buie brought as his guest Danny Kaye. I recall my youngsters going over to greet the comedian and to secure his autograph.

In the mid fifties at a Myrtle Beach meeting of the South Carolina Medical Association, both Dr. Buie and J. F. Byrnes, then Governor of South Carolina, appeared on the program. Rumor had it that Governor Byrnes tried to induce Dr. Buie to come back to South Carolina at the medical school. I sort of wished he had returned to his native state because that would have enhanced the prestige of proctology in South Carolina.

I remember Dr. Buie as a warm friendly man whose words packed authority. His accomplishments and his writings will long be remembered.

— LEON BANOV, JR., M.D.

ACKNOWLEDGMENT

The photograph of Dr. Buie was supplied by Dr. John R. Hill, Editor, *Diseases of the Colon and Rectum*.

President's Page



LEONARD W. DOUGLAS, M.D.: A MAN OF OUR TIMES

Leonard Douglas died Wednesday, September 18, 1985. We lost a friend, a colleague, an advisor and a leader. We miss him.

But each of us is a better person today because we knew Leonard and worked with Leonard. He touched our lives in a special way. We saw his dedication to his ideals through his daily work in medicine, religion and government.

Leonard's entire life shows his dedication to service. He served his country as a member of the United States Navy. He served his religion as a ruling elder of the Belton Presbyterian Church. He served his community as a member of several civic clubs, as a member of the Board of Directors of the South Carolina National Bank in Belton, and as a member of the Anderson County Chamber of Commerce. He also served on the staff of the Anderson Memorial Hospital.

He served his native state as a member of the Board of the South Carolina Department of Health and Environmental Control. And he served his profession in so many ways, through so many important positions.

He was a Past President of the Anderson County Medical Society, an At-Large member of the State Board of Medical Examiners, President of the South Carolina Medical Care Foundation and a member of the Board of Directors of the South Carolina Political Action Committee.

Leonard held many important positions with the South Carolina Medical Association. He was a Delegate to the American Medical Association from South Carolina. Finally in April, Leonard was sworn in as our President.

Although his Presidency of our Association lasted only a few short months, Leonard left us with the outline of the action needed to improve the professional environment of physicians so that they may deliver even better health care for all South Carolinians. It is now our job, each of us, in our own way, to fulfill Leonard's dream. We must take his beginning efforts and bring them to reality in South Carolina. Leonard would want us to do no less.

We miss our colleague. But we also miss our friend. Each of us misses Leonard's friendly smile, his easy manners. He was truly a southern gentleman.

To his wife, Mary Anne, his sons Len and Robbie, and to his three wonderful grandsons, Matthew, John Ryan and Robert, Jr., our deepest sympathy. "Let Yahweh be pleased with a man's way of life and he makes his very enemies into friends." (Prov. 16:7)



J. GAVIN APPLEBY, M.D., *President*



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INFORMATION FOR AUTHORS

Authors should refer to the detailed instructions in the January issue. Manuscripts and other correspondence should be addressed: The Editor, JOURNAL OF THE SOUTH CAROLINA MEDICAL ASSOCIATION, Post Office Box 11188, Columbia, S. C. 29211.

All manuscripts should be accompanied by a transmittal letter with the following paragraph: "This original work has not been submitted or published elsewhere, in entirety or in part. I (we) hereby transfer, assign, or otherwise convey all copyright ownership to the South Carolina Medical Association in the event that this work is published by the SCMA."

We request that manuscripts be concise (no longer than 8 typewritten pages, double-spaced), with no more than ten references. These should be cited in the text in superscript, e.g., "Bottsford, et al.³", and should conform to the following style: "3. Bottsford JE, Bearden RC, Bottsford JG: A ten year community hospital experience with abdominal aorta aneurysms. *J S C Med Assoc* 79: 57-62, 1983." Ordinarily, publication of four small illustrations or tables or the equivalent will be paid for by *The Journal*. Manuscripts should be submitted in duplicate. Reprints will be made available by the publisher.

VENEREAL DISEASES OF THE ANORECTUM

GABOR F. SOVENYHAZY, M.D.*

The classical venereal diseases: syphilis, gonorrhea, chancroid, lymphogranuloma venereum and granuloma inguinale, although commonly known, represent only a minority of the sexually transmitted infections in the United States. Worldwide, about 250 million people are infected annually with gonorrhea, and probably more than 50 million people with syphilis, but these are not the most common venereal diseases of the anorectum. In the United States, the most common are condylomata accuminata and herpes genitalis.

The anorectum can react to all kinds of different insults in very similar ways. Bullous formations, ulcerations, and fissurization are the most common findings in the venereally transmitted diseases. Involvement of the dentate line area, where the skin and the mucosa come together, shows cryptitis. The rectal mucosa can react with increased mucus. These features may give a clue as to which disease is present. A careful history and physical examination including the rest of the body should be carried out. In searching for venereally transmitted anorectal disease, the genitalia and inguinal nodes should be carefully examined. Careful attention has to be paid to the sequential development of symptomatology. A hurried, non-interested patient will not volunteer information even on careful questioning.

CONDYLOMATA ACCUMINATA

Condylomata accuminata, often called venereal warts, are the most common of the venereally

originating diseases of the anorectum. The disease is caused by the papilloma virus (a member of the Papova DNA viruses), a virus different from that of the common wart, verruca vulgaris.

Clinical Picture

First, early in the disease, small discreet, pink, elevated vegetations will appear in the anal canal and on the perianal skin. There might be larger numbers at the anorectal junction area and may involve the rectal mucosa. These nodules might be single but usually are multiple and many times they coalesce. When neglected, they will continue to grow and to proliferate.

Symptoms

The usual complaint is itching and burning at the anal opening, painful defecation, and tenesmus. Anal pain will often cause great difficulty in eliminating the stool. Larger lesions will obstruct the anal opening and also will produce odorous discharge.

Diagnosis

Diagnosis can usually be made from the appearance of the lesions and confirmed by biopsy. Warts are hyperplastic epithelial lesions which microscopically show acanthosis and hyperkeratosis.

Treatment

In the office, smaller lesions can be treated with bichloroacetic acid and podophillin or electrocautery under local anesthesia. Much care must be taken with podophillin at the anal orifice. Larger and multiple lesions have to be treated surgically

* Wallace Wilson Brailsford Clinic, P.A., P. O. Box 2768, Spartanburg, S. C. 29304.

by excision, electrocautery, or laser evaporation and coagulation under local or general anesthesia.

The virus has an incubation period of at least six months. The patient must be free of warts for at least six months to be considered cured.

Recurrent, resistant cases are sometimes treated by vaccination. Vaccine is prepared from the original tissue at the first surgery. There has to be more than 1 gram of tissue available at this time for proper preparation of the vaccine. Six weekly injections of one half ml of vaccine subcutaneously may control the warts in 84 to 90 percent of the cases. A second course of vaccination might result in up to 94 percent success rate just by treatment by vaccine. Most doctors use vaccination though only for recurrent cases.

GIANT CONDYLOMA ACCUMINATUM

(Bushke-Lowenstein Tumor)

The giant condyloma accuminatum is a variant of the anal condyloma. It is more aggressive than the usual anal wart, burrows deep into the tissues which it invades; thus it exhibits malignant characteristics. It may undergo frank malignant degeneration to squamous cell carcinoma.

Clinical Picture

It is a fungating large lesion involving the anal opening and anal canal skin.

Symptoms

Similar to condyloma accumulata but more exaggerated.

Diagnosis

Mostly by appearance and by biopsy. The diagnosis is part of the treatment.

Treatment

Benign lesions are locally excised widely. If malignancy is found, abdominal perineal resection is recommended.

Giant condyloma accuminatum cannot be treated in the office. Small anal condylomata can be treated with bichloroacetic acid or podophyllin. In applying either of these solutions which are commercially available, careful attention has to be paid not to damage the skin surrounding the warts. Tincture of benzoin can be applied to the normal skin around the anal warts after which the exposed area is treated with bichloroacetic acid. The anal canal skin, and especially the dentate

line area, has to be kept dry during application of this chemical agent. The acid can spread through moist surfaces rapidly and cause wide damage. Usually a piece of cotton is applied on top of the treated area to separate it from the opposite skin which can also be damaged by contact with the acid covered condylomata.

HERPES GENITALIS

Herpes genitalis caused by the virus herpes simplex may involve the perianal and anal canal skin.

Clinical Picture

Singular or groups of vesicular eruptions at the anal canal will appear first. When the vesicle pops, an erythematous oozing base will be exposed. These small ulcerations will then become confluent. Careful search has to be made for lesions not only in the anal and genital areas, but covering other areas of the body as well. Bilateral inguinal lymphadenopathy is also common.

Symptoms

The most common symptom is pain, which may be severe and is usually aggravated by defecation. Pruritus and discharge are also common.

Diagnosis

Direct fluorescent antibody technique from the fluid of the vesicle is the most frequently used diagnostic method. Viral cultures can also be made from this fluid. If the lesions are biopsied, intranuclear inclusion bodies are seen in macrophages (Donovan bodies) when Leishman's stain is used.

Treatment

This disease is usually self-limiting and treatment is mostly symptomatic. Recommended are sitz baths or warm compresses, keeping the anal area clean and dry. After baths, a heat lamp or hair dryer might be used to dry the anal skin. Mild analgesics are recommended. Steroids are contraindicated. Acyclovir (Zovirax) is the most recently developed topical medicine. It inhibits viral activity in vitro and helps to shed the virus in vivo.

Primary concern is Acquired Immunological Deficiency Syndrome (AIDS). Contacts of these patients have to be carefully searched for and also examined.

GONORRHEA

Anorectal gonorrhea is transmitted almost exclusively by anal intercourse in men. Women might acquire it from infection from the genital organs. Gonorrhea is caused by bacterial infection with *Neisseria gonorrhoeae*, which is a gram negative diplococcus.

Clinical Picture

Most patients are asymptomatic. Common complaints are pruritus, tenesmus, and a slight mucoid discharge. Painful defecation might be present. Rectal pain in excess of clinical findings should alert the physician to possible gonorrheal proctitis. Gonorrheal dermatitis is rare as the infection usually involves the rectal mucosa. An anal fissure might be seen. Most patients are going to be men and a high percentage of them are homosexuals although history might be hard to elicit.

Diagnosis

Proctosigmoidoscopy is an absolute must. The examination might be painful and has to be carefully done. The rectal mucosa will be found to be erythematous, edematous, and friable. Occasional ulcerations are seen. Copious mucus discharge might be present. Rectal culture establishes the diagnosis and it has to be made by sterile swab on a chocolate agar medium (Thayer Martin medium). One should always test for syphilis as well.

Treatment

Irradiation of anorectal gonorrhea is more difficult than that of the genito-urinary infection. Treatment of choice is procaine penicillin 4.8 million units intramuscularly in two divided doses, followed by 1 gram oral probenecid in the office. In individuals allergic to penicillin, tetracycline 1.5 grams by mouth is followed by 500 mg. four times a day for four days. Streptomycin is another drug of choice (2 grams IM). Careful follow-up is very important as more than one treatment might be necessary. Contacts have to be searched for and also treated.

SYPHILIS (Lues)

Syphilis is caused by *Treponema pallidum*. There is usually history of contact about three to five weeks prior to the appearance of primary lesions. There are three different kinds of lesions that can be present in syphilis in the anal area.

Clinical Picture

1. *Primary lesions* — There might be an indurated fissure at the anal verge or in the anal canal. These ulcers might be single or multiple and so called "kissing lesions" might be present. This means that two fissures are present on the opposite sides of the anal canal. Fissures might be in atypical locations (on the left side or anteriorly). These lesions might be painful or painless. Bowel movements might be painful. Tenesmus and mucus discharge is often present. Usually inguinal adenopathy is present.

2. *The secondary lesion* in syphilis is condylomata lata. These are flat warts appearing on the anal canal skin and perianal tissue. The initial maculopopular rash gives rise to a proliferating weeping mass oozing spirochetes. These lesions might be flat and scaling, red, and are usually indurated especially in the anal area. They may become vegetative and foul smelling. The second state of the disease usually develops two to six months after the primary infection or usually six to eight weeks after the primary chancre. Both primary chancre and the condylomata lata might exist simultaneously.

3. *The tertiary lesion* of syphilis is a gumma of the rectum. This is a fungating lesion of the rectum which can be mistaken for an adenocarcinoma. Tabes dorsalis may also involve the rectum resulting in rectal pain, atonic sphincter or even saddle anesthesia.

Diagnosis

It might be difficult to differentiate syphilitic fissures from benign fissures. The original fissures might even heal without treatment and some might be mistaken for benign fissures. A negative serology test does not exclude syphilis, as the serology does not become positive for several weeks. Secondary and tertiary stages of syphilis are almost always associated with positive serology. Some recommend determination of blood serology before operating on virtually any anal fissure.

In differentiation, lesions of condyloma latum are usually fewer, smoother, and flatter than those of condylomata acuminatum. Rectal gumma can mimic carcinoma and biopsies are important. When diagnosing atonic sphincter and saddle anesthesia, a tumor of the spine in the cauda equina area of the spine has to be ruled out. Dark field examination of scrapings often show orga-

nisms. Biopsies of syphilis will show tissue infiltrate with round cells, plasma cells and fibroblasts. Often proliferation of endothelial cells is seen. Biopsies of condylomata lata show acanthosis, edema and broadening of the rete ridges. Non-specific chronic inflammatory infiltrate may be present in the tissues.

Treatment

Treatment with benzathine penicillin G 2.4 million units IM in two divided doses is the drug of choice. In patients allergic to penicillin, tetracycline 500 mg. orally four times a day for fifteen days is recommended. An alternative drug of treatment is erythromycin. Some recommend treatment every three months for a year and then annually. Contacts, again, have to be carefully searched for and also treated. A good relationship between patient and physician can hardly be emphasized enough.

RARE VENEREAL DISEASES OF THE ANORECTUM

Less common diseases of the anorectal area are granuloma inguinale, lymphogranuloma venereum, herpes simplex infection, chancroid and molluscum contagiosum.

GRANULOMA INGUINALE

Although more common elsewhere, granuloma inguinale is rare in the United States. It is a bacterial infection of the skin and mostly involves the anal, genital, and inguinal areas. It is caused by *Calymmatobacterium granulomatis*.

Clinical Picture

This condition usually starts with small vesicles and popules and skin nodules which do not heal but spread through the anal skin. Next, ulcers form and then due to skin proliferations, cauliflower-like lesions develop. If untreated, severe tissue destruction might result in anal stenosis and possible malignant degeneration. Usual complaints include pain, pruritus, presence of a mass and foul-smelling mucus discharge. Anal stenosis results in painful defecation.

Diagnosis

Punch biopsies are recommended in different areas of the lesion. Using Bright's Stain, Donovan bodies (deeply staining bipolar rods), are seen in the cytoplasm of microphages. Enlarged mono-

nuclear cells are common.

Treatment

Drug of choice is tetracycline which has to be given for extended periods of time, for 20 to 40 days. Surgical excision of remaining lesions is important to rule out malignancy. Anal stenosis after resolution of the disease is often irreversible due to tissue destruction.

LYMPHOGRANULOMA VENEREUM

Lymphogranuloma venereum is a rare disease. It is caused by *chlamidia trachomatis*. This is a filterable virus most often transmitted by anal intercourse or genital infection. It is mostly seen in homosexual men, most of whom are black.

Clinical Picture

The virus spreads from viral proctitis or cervical infections in women, upwards through the lymphatic drainage of these structures. Involvement of the perirectal lymphatics results in tubular fibrosis of the rectum usually several centimeters in length and is characteristic of the disease. Initial lesions might be skin vesicles associated with ulcerative proctitis. Painful fissures and painful defecation might be present associated with mucus discharge, bleeding, and tenesmus. Proctitis might be followed by fistulization and stricture formation at the anal canal level as well as higher up. Regional lymphadenopathy usually appears weeks after the initial lesions. Enlarged lymph nodules often coalesce to form a large mass.

Diagnosis

Complement fixation test is the most commonly used method of diagnosis. Increased titers against antibodies start to appear about a month after infection. Frei test is less often used nowadays. It is an intradermal injection which becomes indurated similarly to the tests for tuberculosis. Biopsies of the rectal mucosa will show non-specific inflammation, infectious granulomata and stellate abscesses. Laboratory tests might show reversed albumin globulin ration. Fibrosis might be prominent in long-standing disease. The disease has to be differentiated from chronic ulcerative colitis or proctitis, Crohn's disease and carcinoma. Coexistent carcinoma of the rectum is quite frequent.

Treatment

VENEREAL DISEASES

Broad-spectrum antibiotics especially tetracycline are treatment of choice. Tetracycline is given at 250 mg. four times a day for four to ten days and then maybe twice a day for another two weeks. Symptoms are eradicated with antibiotics but stricture cannot be cured medically. Dilatation might be more harmful than helpful, causing bleeding and intraperitoneal tear. Colostomy is sometimes used to relieve complete obstruction. Colon resection for higher lesions and abdominoperitoneal resection for low stricture are the most effective, especially if sinuses and fistulas are also present. Occasionally a sphincter-saving pull-through procedure might be used. Patients have to be followed long term to rule out the development of carcinoma in the future.

HERPES SIMPLEX

Herpes simplex infection often presents itself in the anal-genital area with acute limited vesicular eruptions near the mucocutaneous junction. Patients often have fever. Lesions might often be seen elsewhere on the patient's body. Complaints include pruritus, pain and lymphadenopathy. Diagnosis can be established by a viral culture but culture is often superfluous as this disease is self-limiting and lesions spontaneously heal in about one to three weeks. Local symptomatic treatment is recommended.

CHANCROID

Chancroid is a very rare anal disease. It is caused by a gram negative bacillus, *Hemophilus Ducrey*. This condition is more common in tropical and subtropical areas among poor popula-

tions. Disease begins with anal or genital maculopopular rash. The pustules rupture and form multiple punched out ulcers with irregular, undermined edges. Within about two weeks of the initial lesions, inguinal lymph node enlargement develops which might ulcerate and lead to perforation of the lymphatics. The inguinal node is called a *bubo*. Lesions, in addition to the anal area, might also be seen on the hands, eyelids, and elsewhere on the body. Diagnosis is established by demonstrating the presence of *Streptobacillus* on bacterial smears. Treatment of choice is sulfonamides; usually sulfathiazole by mouth. In patients allergic to sulfa drugs, oral tetracycline is the treatment of choice.

MOLLUSCUM CONTAGIOSUM

Molluscum contagiosum is a communicable viral infection by a poxvirus. It can involve the skin anywhere on the body including the abdomen, thighs, groin, genitalia, and buttocks. Perianal involvement is most often seen in homosexual men.

Initial lesions begin as papules which often develop a central umbilication. The usual complaint is pruritus. Biopsies to establish the diagnosis often show proliferation of the rete ridges and deeply cratered ulcerations. So called molluscum bodies are found in the cytoplasm of the malpighian layer of the skin. Treatment may not be necessary as the disease is self-limiting and the lesions usually heal without much scarring unless infection ensues. Larger lesions can be electrocoagulated or curetted with the aid of ethyl chloride. □

MANAGEMENT OF POLYPS OF THE COLON AND RECTUM

LOUIS F. KNOEPP, JR., M.D.*

The word polyp is derived from the Greek words poly (many) and pous (foot). It has come to mean in current usage any swelling or protrusion from the lining of the alimentary tract, the respiratory tract or urogenital tract. It usually means a benign growth. Colorectal polyps, when large, often show many sessile lobulations, hence the name polyp or "many feet."

The management of colorectal polyps has changed since the advent of the colonoscope with the cautery snare. About twenty years ago polyps were felt to be mostly benign, and have no malignant potential;¹ now that removal of almost all polyps is possible endoscopically, pathologists feel that most polyps have a significant malignant potential.

The true incidence of polyps of the colorectum is not known, ranging in autopsy series from .42 percent to 69 percent.² In this last series, the colon was examined with a hand lens. In a personal series of 100 consecutive patients being colonoscoped, the incidence of polyps of any size was 33 percent.³

PATHOLOGY

Histopathologically, most polyps fall into four basic groups — hyperplastic, adenomatous, villous, or carcinomatous. Adenomas and villous polyps are termed neoplastic, and felt to be pre-malignant. On microscopic examination they show dysplastic epithelium (greek dys = disordered, and plasia = growth). Dysplasia is graded pathologically over a spectrum from mild to moderate to severe to carcinoma in situ. Carcinoma in situ shows no invasion below the muscularis mucosa of the polyp; if it does invade below the muscularis mucosa, it is termed invasive carcinoma. This may occur into the bowel wall per se, or merely into the head of the polyp if the muscularis mucosa is pulled up into the head as is seen in the larger polyps (Figure 1). The incidence of carcinoma arising in a polyp goes up if the polyp becomes larger; it is also higher in villous

polyps than in adenomatous polyps.

Hyperplastic polyps are not felt to be pre-malignant. They do not show dysplasia. They are usually below 5 mm in size and almost always below 10 mm in size. They are usually not pedunculated and are usually the same color as the surrounding mucosa. They are most common in the rectum and they are frequently multiple. Biopsy may be necessary to diagnose them with certainty.

Other types of polyps less commonly found include frank carcinoma (carcinoma with no residual benign polyp tissue present — always larger than 7 mm in my experience), carcinoid tumors (considered benign if less than 2 cm in size), leiomyomas, lymphoid follicles, juvenile polyps, and psuedopolyps (composed of nubbins of inflammatory granulation tissue and more common in inflammatory bowel disease).

MORPHOLOGY

Morphologically polyps may be either pedunculated (stalked) or sessile. Pedunculated polyps smaller than 1 cm have about a one percent chance of malignancy. If larger than 1 cm, 10 percent harbor malignancy, but they metastasize to regional nodes less frequently than sessile polyps.⁴ They are felt to become pedunculated over a period of time with action of the intestinal contents pulling on the benign tissue. If malignancy develops in the head of the polyp, with the patient being followed by barium enemas, the stalk will be seen to shorten and disappear and the polyp grow into an invasive ulcerated lesion. This has been demonstrated in about three percent of

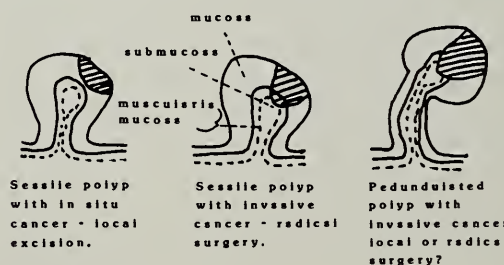


Fig. 1. Polyps with cancer.

* Wallace Wilson Brailsford Clinic, P.A., P. O. Box 2768, Spartanburg, S. C. 29304.

patients so followed.⁵ Sessile polyps are also usually benign if under 1 cm in size (one percent are malignant) but also show a 10 percent incidence of malignancy if over 1 cm in size and a 50 percent incidence if over 2 cm in size.⁶

Since polyp size is an important indicator for both neoplasia and malignancy, it is important to be able to accurately estimate the size of lesions endoscopically. This can be done via the standard size rigid sigmoidoscope by placing the tip of the open barrel over the polyp and comparing the size of the polyp to the inside diameter of the barrel. The standard plastic Welch Allen sigmoidoscope measures exactly 16 mm across the inside of the distal barrel. This maneuver is not possible through the flexible fiberoptic sigmoidoscope or colonoscope, and since magnification is used, everything looks larger than it is. However, the unopened flexible biopsy forceps are 2 mm in diameter; if opened, they measure 7 mm. By placing the forceps in juxtaposition to the lesion, a fairly good estimate of the size can be made (Figure 2).

The American Society of Gastrointestinal Endoscopy also recommends that if one neoplastic polyp is found in the rectum or lower colon, a complete colonoscopy should be done to search for synchronous (simultaneous) lesions, which are reported to occur in as high as 50 percent of patients. It has also been recommended by this society that serial colonoscopy should be done yearly until the colon is free of neoplastic polyps; then the frequency of colonoscopy can be decreased to every three years. The reason for this surveillance is to search for metachronous (interval) lesions. This should ideally be done for life.⁷

MANAGEMENT

Ideally, all polyps of the colorectum should be destroyed, but this is impractical for very small polyps and not necessary for hyperplastic polyps. The current recommendations of the American Society of Gastrointestinal Endoscopy⁷ state that all polyps greater than 1 cm should be removed in toto with an endoscopic electrical snare. The incidence of malignancy in this group as stated previously will be about 10 percent. If the polyp is benign or has carcinoma in situ, this treatment should suffice. If invasive carcinoma is present, a surgical resection of the involved segment of colon is usually necessary, although this can be tempered if a colostomy is needed, and if the polyp has a stalk. Polyps smaller than 10 mm in size

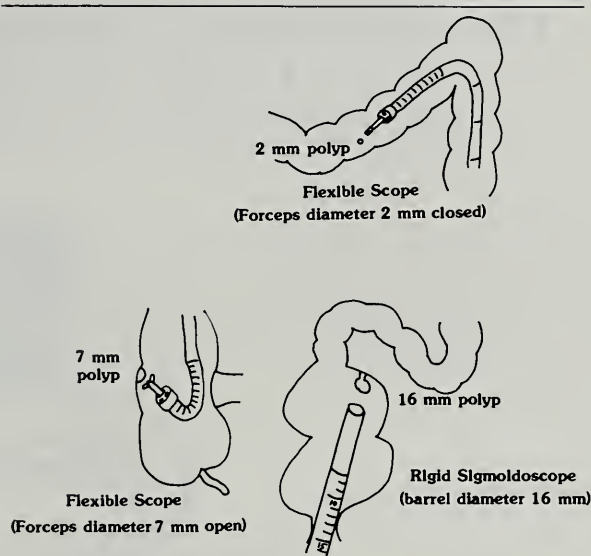


Fig. 2. Sizing Polyps

should ideally all be biopsied and then destroyed by fulguration. This enables one to tell whether or not the polyp is neoplastic (adenoma or villous) or hyperplastic. The incidence of carcinoma in polyps smaller than 5 mm is less than 1 in 1000. Polyps less than 2 mm can be left alone.

SUMMARY

In summary, a polyp is a growth from the mucosal lining of the intestinal tract. It may be hyperplastic or neoplastic; hyperplastic polyps are not pre-malignant but neoplastic polyps are. The incidence of malignancy rises with an increase in size of the polyp, and is higher in villous polyps. Ideally, all polyps should be biopsied and destroyed. Polyps with invasive malignancy usually require a colon resection. Polyps less than 2 mm in size can usually be ignored. Total colonoscopy is necessary at the outset and at intervals to search for other polyps. □

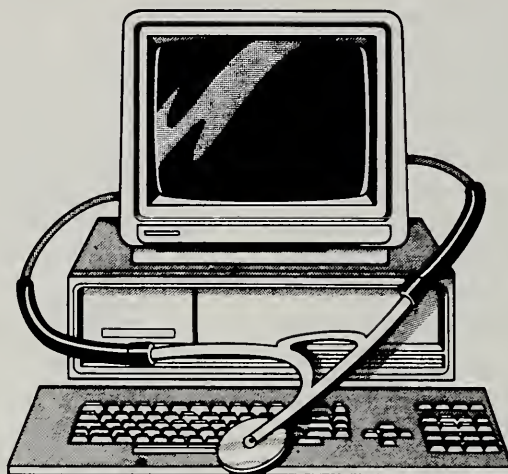
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OUTPATIENT HEMORRHOIDECTOMY BY RUBBER BAND LIGATION

LOUIS F. KNOEPP, JR., M.D.*

Mankind has suffered from hemorrhoids since ancient times; documentation has been evidenced in the Egyptian papyrus.^{1, 2} Surgical excision has been the best therapy over the years, since it removes diseased hemorrhoidal masses more effectively and comes closest to effecting a cure. There is an art to performing a satisfactory hemorrhoidectomy. Indeed, a properly performed hemorrhoidectomy is the foundation of the specialty of proctology.

Many alternative forms of treatment have been proposed, including dietary manipulation, sclerosant injection, cryotherapy, infrared coagulation, laser coagulation, anal dilation, sphincterotomy, and rubber band ligation. All of these have the advantage of ease of application with a shorter convalescence than a standard hemorrhoidectomy.

It is helpful for a physician treating a large number of patients with hemorrhoids to be able to offer a treatment between topical ointments and surgical or operative hemorrhoidectomy. I favor rubber band ligation because of ease of application, low cost, and my previous exposure to this treatment in my colon and rectal fellowship.

I wish to report a personal series of patients with this modality.

CLINICAL MATERIAL

Since 1977 I have been keeping a log of patients undergoing rubber band ligation as an alternative to surgical hemorrhoidectomy. Indications were small to medium-sized internal hemorrhoids presenting with rectal bleeding, and larger combined hemorrhoids in patients who either refused conventional hemorrhoidectomy or were felt to be a poor risk for anesthesia. Relative contraindications included patients with external hemorrhoids only, or with large prolapsing hemorrhoids, rectal procidentia, bleeding diathesis or inflammatory bowel disease.

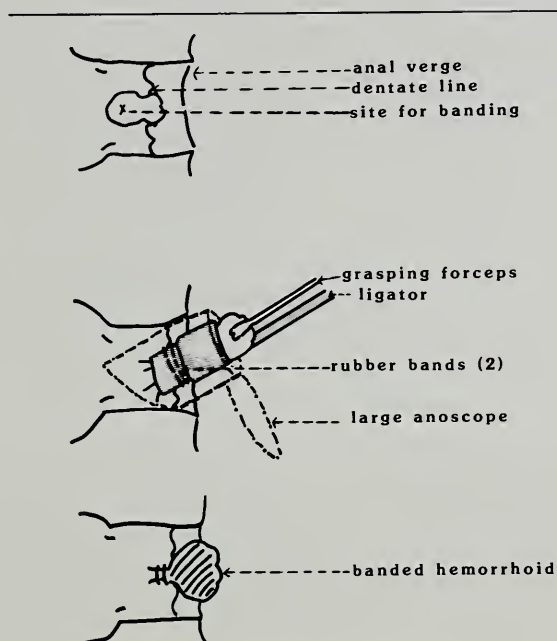


Fig. 1. Technique for hemorrhoidal banding

TECHNIQUE

A large Hirschman is inserted and the rectum is inspected in all quadrants. The largest hemorrhoids are selected first, and pulled in to the drum of the ligator. The grasping forceps must be placed in a little above the actual pile, or else pain is produced. The rubber band gathers up a mound of tissue about 1 cm. in size; the location of the band is about the junction of the internal hemorrhoid and the normal mucosa above the pile. The location of the band is similar to the location of injecting sclerosant solution. (Figure 1) The advantage of banding is that a larger amount of tissue can actually be caused to slough off and still there will be a small scar to cause adherence of the mucosa to the muscular wall of the anal canal. Up to five hemorrhoids may be banded. Sometimes only one or two need banding.

Usually no sedation is required, but an oral analgesic is given for a few days, such as hydrocodone with acetaminophen (Vicodin). The procedure is usually done in the office on Friday so the patient may return to work Monday.

* Wallace Wilson Brailsford Clinic, P.A., P. O. Box 2768, Spartanburg, S. C. 29304.

CLINICAL RESULTS

Between October, 1977 and October, 1984, 64 patients underwent rubber band hemorrhoidectomy (RBH) either in the office (60) or in the hospital (four). Hospital RBH was done as a service to the patients already hospitalized for some other condition. Ages ranged from 30 to 93; half of the patients were male and half female. The number of bandings varied from one to five. No patient returned for a second banding, but four required further rectal surgery. The first patient who required further surgery had large combined hemorrhoids and was banded because he refused conventional hemorrhoidectomy. After several months and continued bleeding and prolapse, he underwent a conventional hemorrhoidectomy with good results. The second patient developed an anal fissure treated by fissurectomy six months later. A third patient developed rebleeding after four years. He then underwent a hemorrhoidectomy, with good results. A fourth patient underwent banding for an enlarged anal papillae. About one week later he developed prolapse of a massive ring of external and internal hemorrhoids, again treated successfully by hemorrhoidectomy.

Two patients developed acute bleeding within seven days of the procedure, sufficient to need transfusions. One patient did fine after this, but the other patient developed cirrhosis and ascites and died within a month of liver failure. Another patient developed chronic rectal bleeding after the rubber band procedure, and was diagnosed as having distal ulcerative proctitis. The proctitis responded to hydrocortisone enemas and sulfasalazine.

DISCUSSION

Rubber band hemorrhoidectomy has been reported by various authors as a good alternative to surgical hemorrhoidectomy for symptomatic hemorrhoids. Long term results are fair, with 89 percent of patients being reported as asymptomatic at an average follow-up of 4.8 years.³ RBH is not as thorough as conventional hemorrhoidectomy, but it is much cheaper and easier to administer. It is better than diet or ointments for internal hemorrhoids.⁴ Complications are few; the most commonly reported is bleeding, which usu-

ally occurs at the time of the band sloughing.

Although basically a simple procedure, RBH requires some technique and experience for best results. Patient selection is very important. External hemorrhoids are not suitable at all. Combined hemorrhoids may benefit from banding, as removal of the internal component may decrease the size of the pile, and the subsequent scar in the anal canal may help control prolapse. Internal hemorrhoids, particularly small to medium size, and associated with minimal prolapse, are best for banding. Small segments of bleeding or prolapsing rectal mucosa may also benefit from banding.

Treatment needs to be individualized. Patients with external hemorrhoids, symptomatic fissures, fistulas, pruritus ani, and proctitis are not good candidates for rubber band ligations. In Canada and in England, perhaps because of the bed shortage and crowded operating schedules, large numbers of patients are treated with rubber band ligation. William Rudd, M.D., in Toronto in 1977, reported 3,000 personal cases with good results.⁵ It was his feeling that 75 percent of patients with hemorrhoids could be successfully managed with banding, with or without the addition of cryotherapy to the banded pile.⁵

SUMMARY

Rubber band hemorrhoidectomy is an effective office procedure for the management of internal hemorrhoids. The procedure is easily learned, but requires some experience in order to select patients properly and to improve technique. In a personal series of 64 patients, most obtained good results but post-banding bleeding happened in two, and further rectal symptoms requiring operative surgery occurred in four. □

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SCMA

NEWSLETTER

October, 1985

SPECIAL SESSION SCMA HOUSE OF DELEGATES

As reported in the September issue of this *Newsletter*, the SCMA House of Delegates is being called into special session on Sunday, November 17, 1985 at 2:00 p.m. at the Ellison Building at the state fairgrounds in Columbia. Keynote speaker will be the Executive Vice President of the American Medical Association, *James H. Sammons, M. D.*

Because of the nature of the business to be considered, the entire physician population of the state is invited. The House will be recessed into a reference committee of the whole to allow non-Delegates and non-members to participate in discussions regarding the current professional liability crisis in the state of South Carolina and nationwide.

Recognizing the seriousness of the situation, the SCMA Executive Committee, acting on behalf of the Board of Trustees, has approved the following Resolution for consideration by the House of Delegates:

WHEREAS, in the past ten years more than 1,700 liability claims have been filed against South Carolina physicians; and

WHEREAS, the Joint Underwriting Association faces an eighteen million dollar deficit and the Patients' Compensation Fund a thirteen million deficit, both of which will be paid by increased assessments on health care providers; and

WHEREAS, the Joint Underwriting Association Board has voted to increase the physicians' premium by thirty percent for next year and this increase does not affect the deficit but only the 1986 activity; and

WHEREAS, the steady increase in the number of liability suits as well as the cost of liability insurance poses a malefic threat to the practice of medicine as well as patient access to the health care system; and

WHEREAS, defensive medicine is contributing significantly to the increased cost of health care in this state; *NOW THEREFORE*,

BE IT RESOLVED, that the House of Delegates of the South Carolina Medical Association, by unanimous action, declares that a professional liability crisis exists in South Carolina; and

BE IT FURTHER RESOLVED, that all physicians in the state be assessed One Hundred Dollars (\$100.00) to create a Tort Reform Fund to finance a public and legislative campaign to correct this insalubrious situation.

APPLEBY SWORN IN AS SCMA PRESIDENT

J. Gavin Appleby, M. D., of St. George, was sworn in as SCMA President at 2:00 p.m. on Wednesday, September 25, 1985, in the board room of the SCMA Headquarters building in Columbia. Charles R. Duncan, Jr., M. D., Chairman of the SCMA Board of Trustees, administered the Oath of Office.

Dr. Appleby will fill the unexpired term of the late Leonard W. Douglas, M. D., who died suddenly on September 18.

Dr. Appleby received his undergraduate degree from the Citadel and his Medical Degree from the Medical University of South Carolina. A family practitioner, he has served on the Governor's Task Force on Health Care Extension and on the Medical Care Study Committee of the South Carolina Legislature. He was a 1981 finalist in the Good Housekeeping Family Physician of the Year award and was the 1981 South Carolina Family Physician of the Year. Among his offices in the SCMA was his brief tenure as President-Elect, several terms as Secretary and Speaker and Vice Speaker of the House of Delegates.

In his comments to the SCMA Executive Committee and staff gathered for the swearing-in ceremony, Dr. Appleby re-dedicated himself to serving the SCMA to the best of his ability and to continuing the work of the late Dr. Douglas.

EMERGENCY BILL SIGNED: DON'T RAISE MEDICARE FEES!

On September 30, President Reagan signed into law the Emergency Extension Act of 1985 which continues several federal programs for another 45 days pending enactment of new legislation.

One of the programs extended under consent bills that were swiftly adopted by both Houses of Congress was the Medicare fee freeze. Without Congressional action and Presidential approval, that freeze technically would have expired at midnight, September 30. Some Congressional leaders had indicated earlier, however, that there was general agreement among Congress to retroactively rollback any Medicare fee increases made if existing law had expired.

NON-PARTICIPATING PHYSICIANS ARE ADMONISHED NOT TO RAISE THEIR FEES BECAUSE OF THIS UNEXPECTED STOPGAP ACTION TAKEN BY CONGRESS. If they do so, they are clearly subject to civil and criminal penalties by the HHS Inspector General - the same penalties that have been applicable since October 1, 1984 when the Deficit Reduction Act became law.

The Emergency action allows Congress more time to complete its budget reconciliation process by extending legislative authority on certain programs that were to have expired October 1. This authority has been extended until November 14.

Congress is expected to enact NEW MEDICARE reimbursement provisions sometime in October. It is likely that House-Senate conferees will meet about mid-month to resolve differences in the new Medicare provisions that have been adopted by the Senate Finance Committee, the House Ways and Means Committee and the House Energy and Commerce Committee.

ELECTION RESULTS: STATE BOARD OF MEDICAL EXAMINERS

Listed below are members of the State Board of Medical Examiners and the Medical Disciplinary Commission, following elections this summer and several run-off races.

<u>MEMBERS OF THE BOARD</u>	First District:	Edgar O. Horger, III, M.D., Charleston
	Second District:	R. Patten Watson, M. D., Columbia
	Third District:	Vernon E. Merchant, M.D., Anderson
	Fourth District:	J. Ernest Lathem, M.D., Greenville
	Fifth District:	James C. Holler, Jr., M.D., Rock Hill
	Sixth District:	Wm. S. Houck, Jr., M.D., Florence
	At Large:	Spencer C. Disher, Jr., M.D., O'burg
<u>DISCIPLINARY COMMISSION</u>	D. O.:	L. Edward Antosek, D.O., Clover
	First District:	Wm. J. Fogle, III, M.D., Charleston John A. Ouzts, III, M.D., Mt. Pleasant John B. Selby, M.D., Charleston
	Second District:	Franklin L. Clark, M.D., Cayce Boyce M. Lawton, M. D., Cameron C. Alden Sweatman, M.D., Columbia
	Third District:	Charles T. Battle, M.D., Seneca James E. Bleckley, M.D., Anderson George W. Smith, M. D., Easley
	Fourth District:	Jack Evans, Jr., M. D., Spartanburg W. Wallace Fridy, Jr., M.D., Greenville A. Frank Weir, Jr., M.D., Spartanburg
	Fifth District:	Richard P. Hughes, M.D., Chester Robert E. Lee, M.D., Sumter James L. Maynard, M.D., Rock Hill
	Sixth District:	Daniel M. Ervin, M.D., Myrtle Beach Emmett W. Flynn, M. D., Marion Joseph W. Dunlap, Jr., M.D., Florence

CONVERSION FACTORS INCREASED FOR WORKMEN'S COMPENSATION

The Conversion Factors for the SCHEDULE OF FEES FOR PHYSICIANS AND SURGEONS under the Workmen's Compensation Act have been increased as follows and are effective NOVEMBER 1, 1985:

<u>SECTION</u>	<u>PRESENT</u>	<u>INCREASED TO</u>
Medical and Surgical	13.0	15.0
Total Radiological	12.0	14.0
Professional Component (Radiology)	2.5	3.0
Anesthesiological Services	16.0	18.0
Nurse Anesthetist	13.0	15.0

The SCMA Occupational Medicine Committee continues to monitor the conversion factors and to work with the Industrial Commission on Workmen's Compensation claims. The SCMA was the only group to testify in support of the conversion factor increase.

1986 SCMA MEMBERSHIP YEAR: JOINT BILLING

Membership dues bills for the 1986 membership year will be mailed this month. Included on the bill will be dues for the American Medical Association, as approved by the Board of Trustees (formerly Council) and the SCMA House of Delegates. You are encouraged to send in dues payments promptly in order to insure that there will be no interruption of SCMA membership and services.

Current AMA President, *Harrison L. Rogers, Jr., M. D., of Atlanta, said of membership in organized medicine, "We can continue to control our own destiny and, in the process, preserve and improve the quality of care this nation depends on. We can do it, that is, if we see all of the situations and problems not as gloom and misery, but as challenges and opportunities."*

BE A PART OF A UNIFIED TEAM! JOIN TODAY! And don't forget SOCPAC/AMPAC - our best long range program ever devised to help elect qualified legislators who understand and appreciate the health care needs of our state and nation.

CAPSULES....

The following physicians have recently been awarded honorary membership status in the SCMA: *Susanne G. Black, M. D., Dillon; George W. Smith, Jr., M. D., Columbia; and J. Harvey Atwill, Jr., M. D., Orangeburg.*

Darwin D. Waters, M. D., Clover, a retired physician from the Wisconsin Medical Association, was awarded affiliate membership status.

LATE BULLETIN: MEDICARE ECONOMIC INDEX INCREASE

As this *Newsletter* goes to press, the SCMA has been advised that the Medicare Economic Increase for the fee screen year beginning on October 1, 1985 is 3.15%. HCFA announced to Medicare carriers that it would make this adjustment in prevailing fees effective October 1.

HOWEVER, THIS ANNOUNCEMENT WAS SUPERSEDED WHEN PRESIDENT REAGAN SIGNED THE EMERGENCY EXTENSION ACT OF 1985 INTO LAW (*see story, page 2*). That action extended the existing Medicare reimbursement limitations on all physicians and the fee freeze for "non-participating" physicians for another 45 days.

Under differing proposals now before Congress, it is likely the full 3.15% increase in prevailing fees will be granted only to physicians who have entered into participating agreements. Because of widely varying provisions contained in three separate reconciliation packages (the Senate version and two House versions), it is uncertain whether physicians who opted out of agreements signed last year or who have just entered into such an agreement for the first time will receive the full increase, or only half, as some bills propose.

No increases in Medicare reimbursement can become effective until November 15. Last year the Medicare economic index rose by 3.34%, but no annual adjustment in Medicare prevailing fee reimbursement was made due to the Medicare reimbursement freeze mandated by the Deficit Reduction Act.

The last increase granted in the prevailing fee level was 5.85% on July 1, 1983.

ANORECTAL ABSCESS AND FISTULA

LAWRENCE H. ERDMAN, M.D.*

Anorectal abscess and fistula are regarded as the same pathologic process because of their common origin. However, they will be dealt with separately since abscess represents an acute condition while the fistula represents a chronic condition. Most anorectal abscesses and fistulas originate in the crypto-glandular dentate level of the anal canal (Fig. 1). At the base of each anal crypt, small glands arborize out into the internal sphincter muscle. This is where most anorectal infections get their start. Some arise from anal fissures which have perforated subcutaneously or through the internal sphincter muscle. Others, though much less common, relate to hemorrhoidal thrombosis, infected prolapse, injections, rubber band ligation or surgery. Inflammatory bowel disease, especially Crohn's disease, is a common offender along with occasionally neoplasm and other granulomatous conditions.

ANATOMY

Cryptoglandular infection passes in one of three directions, e.g., downward, upward or laterally (Fig. 2). The intermuscular or intersphincteric plane between the internal sphincter muscle and the external sphincter mechanism allows the spread of infection in one of the three directions mentioned above. Downward spread along the intersphincteric plane is the most common and results in the perianal abscess. Upward spread along the intersphincteric plane results in the so-called "submucous" or high abscess. This can only be felt in digital rectal examination, and is invisible from the outside. The third possibility, that of lateral extension through the external sphincter muscle, may result in a deep ischiorectal abscess. In my experience, I've found the most common to be the perianal abscess with the downward extension of infection, followed by the less common upward extension creating the high abscess. Perforation through the external sphincter mechanism in a posterior direction results in a deep posterior space abscess or a horseshoe type of abscess.

* Proctology Clinic, 3321 Medical Park Road, Suite 205, Columbia, S. C. 29203.

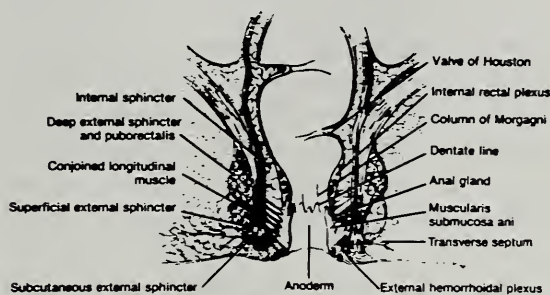


FIGURE 1. Ano-rectal Abscess and Fistula. Ano-rectal Anatomy (After Goldberg S et al: *Essentials of Ano-rectal Surgery*, J. B. Lippincott, 1980).

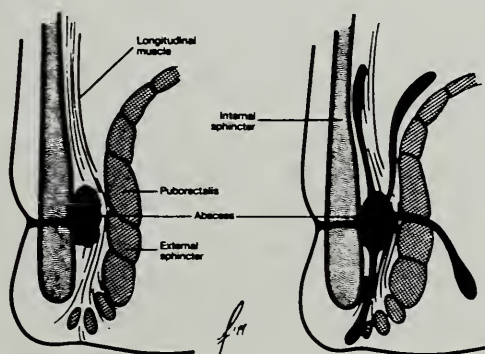


FIGURE 2. Ano-rectal Abscess and Fistula. Avenues of Abscess Extension (After Parks, AG: *Br. Med J.* 1:463, 1961).

DIAGNOSIS

In most cases the perianal abscess is easily detected externally, manifested by induration, swelling, tenderness and often, fluctuation. The high, intermuscular abscess, however, can only be diagnosed on digital examination up in the rectum, manifested by swelling induration and tenderness at the dentate level and above. In the case of ischiorectal abscess, there is deep induration, swelling and tenderness lateral to the anus, and often the patient is very sick with a fever. A deep postanal abscess may be difficult to detect except for induration and tenderness in the posterior midline.

TREATMENT

Anorectal induration and pain usually do not subside spontaneously, and respond poorly to antibiotic treatment. If there is uncertainty as to whether suppuration has actually taken place, the patient should be reexamined within 24 hours. I have found that if patients lose sleep at night because of pain, almost invariably they have suppuration present, and incision and drainage should be carried out. Most perianal abscesses which are superficial, often with fluctuation, can be drained in the office under local anesthesia, as in the case of the ischiorectal abscess. When I drain an abscess in the office, I always tell the patient that there is a fifty-fifty chance of a chronic fistula developing.¹ The high abscess or the deep postanal space abscess should be drained in the operating room under anesthesia as in the case of the ischiorectal abscess. It is tempting, if the patient is taken to the operating room, to search for the offending internal opening at the dentate level. Some have advocated a one-stage procedure by externalizing the internal opening so that fistulectomy will not be necessary as a second-stage procedure.² I have found, however, that often the tissues are so friable in the abscess situation, that it is easy to make a false opening, thereby not accurately identifying the true crypto-glandular source. For this reason it is usually wiser to drain the abscess adequately in the first stage, and plan a second-stage fistulectomy when and if needed. It is important that the abscess cavity be completely evacuated with a large enough opening either radially placed or made in cruciate fashion, so that premature closure will not take place. It is sometimes difficult under local anesthesia in the office to be sure that the abscess cavity is completely drained because of the patient's discomfort. I usually place a small wick of iodoform gauze in the abscess cavity, and remove it in 24 hours. Sitz baths are started the following day.

ANORECTAL FISTULA

Anorectal fistula is the chronic manifestation of erstwhile abscess and has the same etiology. The primary fistulous opening is usually cryptoglandular at dentate level. The secondary opening is in the perianal area at varying distances from the anal ring. Goodsall's rule, although not always true, is very helpful in localizing the site of the internal fistulous opening. Visualize an imaginary

transverse line across the central portion of the anus. If the external fistulous opening is anterior to this line, the tract runs directly to the internal opening in the same quadrant of the anal canal. If the external opening is posterior to the imaginary transverse line, the fistulous tract runs a curved route to the posterior midline of the anal canal at dentate level. I am cautious about probing fistulous tracts in the office, but usually do give it a try with a small lacrimal type probe. Most of the straight probes available are much too thick and difficult to torque and have no handle. Creation of pain and false passages is a contraindication to probing. With luck, the internal opening can be detected, sometimes quite easily, making planned surgery more obvious. It is reassuring to be able to go to the operating room knowing exactly where the fistulous tract is located. Unfortunately, this is often not the case.

TREATMENT

The aim of treatment of an anal fistula is to exteriorize the internal opening so that it becomes part of the anal orifice. By so doing, stool can exit without being caught by the internal opening. Often the internal opening is so small that only bacteria can pass through it. We know that the rectum is able to develop pressures of 60-70 millimeters of Mercury, so it is easy to see why bacteria or small stool fragments can get forced into a internal fistulous opening. When a probe is passed through the external opening and made to emerge through the internal opening, the stage is set for exteriorizing the internal opening. When all of the tissue, skin and muscle is divided overlying the probe, the internal opening then becomes continuous with the anal canal. Except for a very superficial subcutaneous fistula, which may be done in the office under local anesthesia, fistula surgery must be done in the operating room, preferably under spinal or general anesthesia. In some cases it may not be necessary to lay open the entire length of the fistulous tract. In recent years there has been a trend toward leaving the external aspect of the fistula intact as long as the primary opening up in the anal canal has been completely removed, sometimes with excision of a small wedge of internal sphincter muscle.

Sometimes a real problem is the question of how much sphincter muscle can be safely divided to externalize the fistulous tract without causing

sphincteric incontinence. In the posterior midline one can safely divide the external sphincter mechanism as long as the puborectalis muscle is left intact. With the incision directly in the midline, the divided external sphincter muscle will come back together well during healing. Anteriorly and laterally, however, the problem is very different. Total division of the external sphincter muscle, even though the puborectalis fibers are left intact, may result in incontinence and require later sphincteric repair. Usually, division of one-half of the thickness of the external sphincter muscle mechanism is safe; certainly in the lateral quadrants. If the greater depth of external sphincter muscle needs division in order to unroof the probe placed in the fistulous tract, staging of the muscle division is preferable. To do this I have used a rubber band seton.³ The rubber band is passed around the remaining undivided muscle and tied to itself. At the end of three weeks, when the wound has begun to heal, the rubber band seton is tightened in the office in order to start division of the remaining muscle bridge. Another two or three office sessions of seton tightening every ten days may be required before the muscle is completely divided. By doing this, the muscle ends are more likely to become embedded in surrounding scar more closely in apposition to one another than if the muscle division is performed in one stage. One stage division of the muscle may allow wide separation of the muscle ends so that incontinence

is more likely to result.

The treatment of anal fistula remains a difficult area of anorectal surgery. Sometimes the internal opening cannot be identified even with careful operating room exposure. When this happens, the possibility of persistent fistula exists.

Incontinence resulting from fistula surgery is a constant threat. If the puborectalis muscle is divided, incontinence is assured. A great deal of judgment is required in predicting the safety of external sphincter muscle division. A well-muscled young man can tolerate much more sphincteric division than an elderly lady with already weakened muscles.

The management of fistula associated with Crohn's disease is usually restricted to conservative incisions to drain abscesses. The fistulous tracts are often complex and do not lend themselves well to standard fistulectomy procedures.

SUMMARY

The care of perianal abscess and fistula is briefly outlined. For more detailed information, standard surgical texts should be consulted. □

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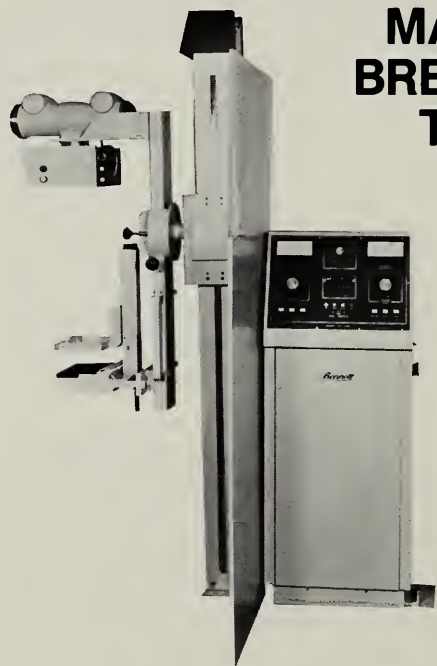
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FINANCIAL CHECKUP

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WHAT YOU SHOULD KNOW BEFORE YOU BUY STOCK

Successful investing requires more than good luck.

If you followed the steps outlined in the first two issues of this series, you are now prepared to examine the "bare bones" of a company.....
It's all a matter of getting down to fundamentals.

Get The True Picture.

As its name implies, fundamental analysis - as the experts call it - is a way to look at "the fundamentals," the important characteristics of your company and the industry to which it belongs. It's a way to get a true picture of your company before entrusting it with your valuable investment dollars.

Basically, this type of analysis is a process of evaluating common stock by studying such features as the company's earnings, dividends, price/earnings ratio and the economic outlook for the industry as a whole. The ultimate aim of fundamental analysis is to help you, the investor, choose what to buy (or sell) and why to buy (or sell) it.

Just as you wouldn't want to buy, say, a car without first taking a good look at all its features and at your own needs and finances, you wouldn't want to buy stock on a whim without first making some broad comparisons. The first consideration is do the company's objectives match your own? After all, what's the point of buying a pair of shoes that don't fit (at any price!) or a stock that has features that you don't need or want? Management's stated objectives, along with detailed financial information, can be found in its annual report. Or you may even want to attend annual meetings. However you go about it, make sure the company you're considering has your best interests at hand.

Check the Bottom Line.

As with any item you're thinking of buying, some features are more important than others - for every buyer. When purchasing common stock, the bottom line is profit. How much extra money (over and above its expenses and after taxes) is your company able to generate? If your company isn't generating a favorable return on its money, then maybe you'll want to look for a company that is.

Net earnings - the company's profits after all expenses and taxes have been paid - give a good indication of how your company is performing. Although a company's net earnings are important in and of themselves, perhaps a more important use of this number is as a tool for comparison. By dividing net earnings by stockholders' equity (the funds originally received from shareholders, plus retained earnings) you come up with what is called return on equity. This is

a measure of the rate of return the company has achieved based on its level of stockholders' equity. Generally, a return on equity of less than 10% is considered unfavorable, but this may vary from industry to industry.

Net earnings can also lead you to other means of analysis. For example, by taking net earnings, subtracting the company's dividends and then dividing the result by net earnings you come up with a company's retention rate - the degree to which a company is retaining earnings (not paying them out as dividends).

To take this process one step further, multiply return of equity by the company's retention rate and you get a company's reinvestment rate - a true measure of a company's growth potential. If either return on equity or the retention rate goes up, the company's reinvestment rate will naturally go up, enhancing its growth prospects for the future. That's because, as we mentioned, the more money a company retains and reinvests in the business (i.e., to expand future business) the greater its potential for growth. In contrast, a company that pays a high dividend may or may not also have a high reinvestment rate.

No matter what your short- or long-term investment goals, you'll want to make sure a company's longer term financial prospects are favorable by looking at the figures we've just described. They provide a good indication of how healthy your company is now and how it should fare in the future. Of course, if you're an income oriented investor, you'll also want to pay special attention to a company's dividend policy over the years (i.e., has the company consistently provided dividends?). On the other hand, if growth is your primary aim, you'll want to focus on whether the company's investment policies provide adequate returns to ensure future earnings increases.

FURTHER INFORMATION

If you would like to receive further information on any of the topics covered in this newsletter, please write to Martin Lefkowitz, CFP, E.F. Hutton & Company, Inc. 2700 Middleburg Drive, Suite 200, Columbia, SC 29204; or Call (800) 922-1112.

* * * * *

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ANAL FISSURE

RICHARD T. ALIA, M.D.*

Anal fissure, a common disease of the anal canal, causes an enormous amount of suffering far out of proportion to its size. It is almost always found either at the posterior or anterior commissure. The pathology usually consists of a triad of a hypertrophied anal papilla, a sentinel pile, and a fissure between these two structures. The fissure itself represents a vertical discontinuity in the lining of the anal canal. The hypertrophied papilla is a common structure caused by chronic infection at the dentate line. The sentinel pile, a heaped up external skin tag, is seen at the anal orifice just distal to the fissure. Fissures are usually singular, but sometimes may be present both at the anterior and the posterior commissures. Anterior fissures are more common in women. Often the exposed portion of the internal sphincter muscle can be seen at the fissure's base. The physician should remember that fissures may develop in locations other than the anterior and posterior quadrants.

ETIOLOGY

The cause of anal fissures remains obscure. Certainly constipation can be a major factor. Most patients will report that all their lives their bowel movements have been soft and regular. They are quite proud of the fact in most instances they have no bowel problems. They will report that on one particular occasion associated with a rather hard bowel movement when they had to strain and push, they experienced pain and observed bleeding. Chronic pain and spasm of the surrounding sphincter muscles prevents healing, and chronicity ensues.

There is also a form of anal fissure which can be secondary, resulting from anorectal surgery. Also, any surgery on the anal canal which results in secondary stenosis and narrowing of the caliber of the lumen of the anal canal may lead to fissure formation, brought on when a large bowel movement passes through the stenotic anal canal.

SYMPTOMS

The chief symptom of anal fissure is pain with bowel movement. The pain is described by the patient as being a "burning" or "cutting" or "tearing" sensation at the anorectum during the actual passage of the bowel movement. The pain may remain for several hours and, sometimes the entire day, gradually decreasing as time passes. Usually the patient feels best in the morning prior to having a bowel motion, and then the same cycle of pain on bowel motion repeats all over again. With some patients the passage of bowel motion is so agonizingly painful that the patient will refrain from having a bowel movement several days simply to avoid this pain. The next most frequent symptom is bright red bleeding with bowel motion. This bleeding is described by the patient as spotting on the toilet paper. Occasionally there is streaking of bright red blood on the stool, and even dripping of blood into the commode. Never is there blood mixed in with the stool. The third most common symptom is that of swelling or protrusion at the anus, usually due to the inflamed skin tag at the end of the fissure. Occasionally there is staining of the underclothes as well as itching. Also, female patients with an anterior fissure may describe some difficulty in urination. In many cases the symptoms of fissure disease may also be associated with those of hemorrhoid disease.

DIAGNOSIS

Diagnosis is made by careful inspection of the anal canal. Remember that these patients have a great deal of pain and the examiner should be extremely gentle. Inspect the anal orifice first before inserting the index finger. With the patient in the jack-knife position, the buttocks are carefully spread apart; under a good light the physician examines the posterior and anterior commissures by gently separating the tissues at the anal orifice. In most cases this will display the fissure quite nicely. Following this examination digital rectal examination can be carried out. To minimize the pain of examination it is often helpful to place a small amount of Xylocaine Oint-

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ment 2-5% within the anal canal by using a Q-tip. If the examiner is very gentle and gradually overcomes the spasm of the sphincter muscle, he can do a better digital rectal examination. The fissure may be felt as an ulcer either in the posterior or anterior commissure. Other associated diseases such as hemorrhoids, hypertrophied papillas, etc., can also be diagnosed at that time. If the examiner has been very gentle, it is usually possible to proceed with proctoscopic examination. If ever the physician were to proceed first with proctoscopic examination, he will never get another chance to examine that patient. Sometimes anosopes and proctoscopes are placed above the area of disease, so unless careful inspection at the anal orifice is carried out, the fissure can be missed.

Anal fissures can be associated with secondary complications. The severe pain caused by the fissure may lead to secondary fecal impaction. The fissure may produce an abscess and/or fistula. Longstanding untreated fissures lead to a fibrotic, tightly contracted internal sphincter, termed anal stenosis. Cancer of the anal canal secondary to benign fissure is a rather rare event.

DIFFERENTIAL DIAGNOSIS

The differential diagnosis of anal fissure includes other conditions of the anal canal which produce pain, swelling, and bleeding. Pruritus ani with superficial cracking of the anal skin, sometimes referred to as the fissuroid syndrome, is commonly seen. Crohn's disease may have anal manifestations. Squamous cell carcinoma of the anal canal, or adenocarcinoma of the rectum invading the anal canal sometimes can be present. Syphilitic fissures and those of other venereal diseases can occur.

TREATMENT

The treatment of anal fissure may be medical or surgical. Medical therapy consists of improved bowel habit and avoiding constipation. This is done by the liberal use of stool softeners, particularly bulk as Konsyl-D, Effersyllium, Hydrocil, Metamucil and wetting agents such as Surfak and Kasof. Also the alleviation of pain is welcomed by the patient. This can be done by sitz baths and the application of an anesthetic cream or ointment directly to the anal fissure. Suppositories usually pass the fissure and reside in the rectal ampulla providing little help for the fissure sufferer. How-

ever, the application of an anesthetic steroid cream directly to fissure by the patient may help to relieve the pain. In no way does this treatment hasten the healing of the fissure, but does give the patient considerable symptomatic relief. Sitz baths are also helpful in relaxing the anal sphincter and lessening pain.

Dr. Eugene Salvati has popularized the old form of treatment where the anal fissure is touched with a 10 percent solution of silver nitrate. He treated the patient with stool softeners and lubricating suppositories such as plain Anusol, and the application of 10 percent silver nitrate periodically until the fissure heals. However, there are others who feel that the application of silver nitrate has no place in the therapy of anal fissures because it is damaging to the tissues and is painful. However, I have used this form of therapy on patients who are poor candidates for any type of surgery and have been gratified by the results. A 10 percent solution of silver nitrate is not very painful and in some ways seems to help reduce the pain and accelerate the healing. Silver nitrate sticks should never be used.

In recent decades, the surgical treatment of anal fissures has undergone an evolution. One of the early forms of treatment was to stretch the anal canal to allow introduction of three or four fingers. This stretching of the anal sphincters was usually done under anesthesia and had the effect of temporarily paralyzing both the internal and external sphincter. This temporary treatment, lasting for several days or a week, would help healing. However, during this process some of the sphincter fibers were torn, leading to bruising and discoloration in the perianal area. Often the fissure itself would be torn widely, but there would be almost complete pain relief. This procedure had several complications. On occasions, painful edema would occur in the perianal tissues. Occasional prolapsing and thrombosis of the hemorrhoids would occur. Functional results were usually good, but there was an unacceptable number of patients who became partially or completely incontinent. So, this form of treatment never became very popular in this country.

Another form of treatment was excision of the anal fissure itself, and the advancement of some form of skin graft over the site of fissurectomy. Although this form of treatment had considerable failures, it is still practiced today when other modes of therapy have been unsuccessful.

ANAL FISSURE

The current treatment of choice is a left lateral internal sphincterotomy. Originally this sphincterotomy was performed at the base of the fissure. However, because of the alleged "key hole" deformity which would occasionally occur when this sphincterotomy was performed at the base of the fissure, the sphincterotomy is usually performed in the left lateral quadrant. Some surgeons refer to the procedure as a lateral pectenotomy. It is not necessary to excise the fissure, but on occasion there is a very large sentinel pile or hypertrophied papilla which can be removed. The internal sphincterotomy may be performed in conjunction with a hemorrhoidectomy or may be the only procedure performed. This procedure can be carried out under local anesthesia, spinal anesthesia, or general anesthesia depending on the individual situation. The sphincterotomy can be performed either by an open or closed method. In the open form of sphincterotomy an elliptical incision is made in the left lateral quadrant exposing the internal sphincter muscle, then the distal end of the sphincter is divided up to the dentate line. The wound is left open. In the closed form of the sphincterotomy, the intersphincteric groove is located by palpation. A small incision is made in a radial fashion over the outer border of the internal sphincter muscle, and then the end of the internal sphincter muscle and external muscle is visualized

through this incision. The internal sphincter muscle is separated from the underlying external sphincter muscle and from the overlying anoderm with blunt dissection. Then the sphincter is divided either with a knife or electrical cautery or scissors. Compression is placed on the wound to achieve hemostasis and the small incision is closed with several sutures. This form of therapy has been so satisfactory that a large number of surgeons operating on the anorectum prefer this form of management. In almost every instance the fissure heals promptly within a few weeks and the sphincterotomy wound heals without complication. There are far fewer complications involving alteration of the anal sphincter function following this treatment.

SUMMARY

Anal fissure, a common disease, produces a great deal of pain and discomfort to the patient. Careful history taking and examination of the patient will usually provide the diagnosis without expensive laboratory tests or procedures. In all but the most recalcitrant anal fissures the current preferred treatment is left lateral internal sphincterotomy. The results have been very gratifying. The patient acceptance has been very satisfactory. □

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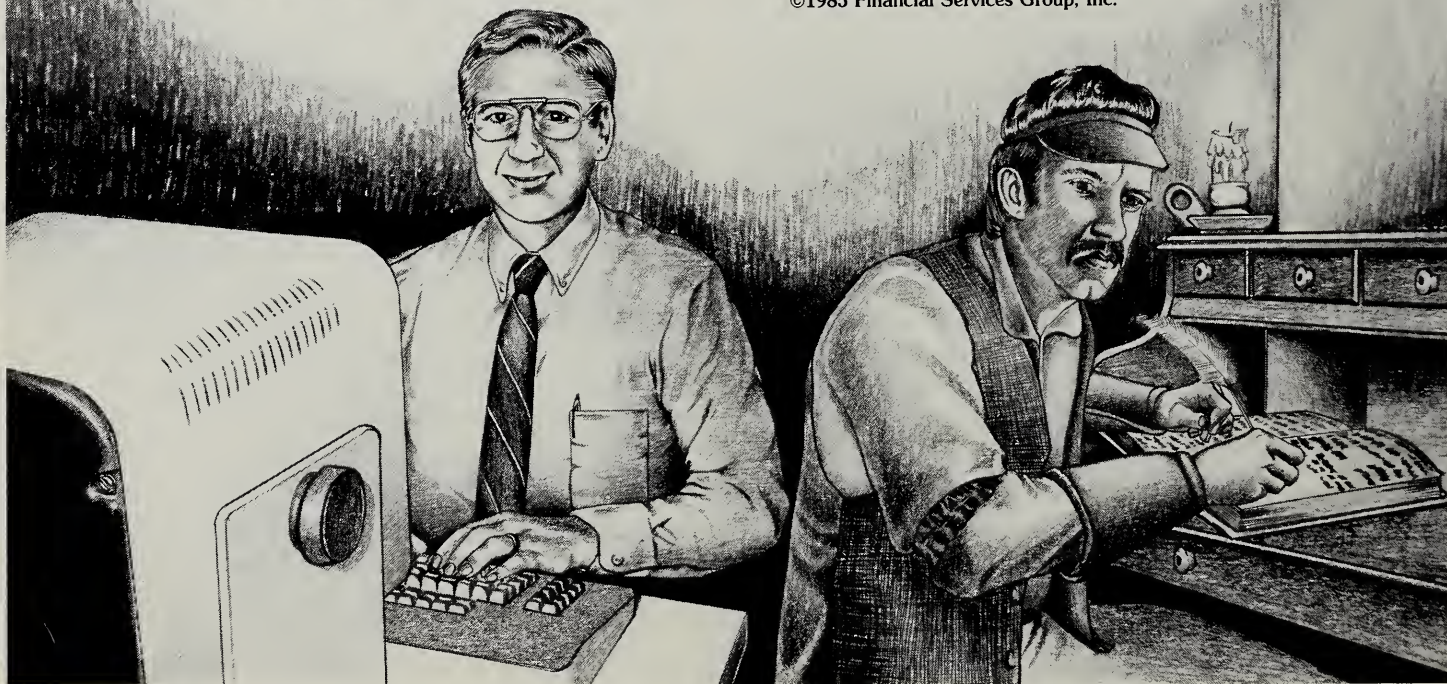


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PRURITUS ANI AND ANAL HYGIENE

LEON BANOVA, JR., M.D.*

Some may think pruritus ani is a new clinical entity. It is not. The earliest manuscript completely devoted to anorectal disorders, the Chester Beatty Medical Papyrus, devoted ten of its 41 remedies to the management of anal itching and irritation.¹ The ancient Egyptians had that problem too. Over the years each generation of physicians has tried to discover "new" ways to treat this embarrassing, tormenting, tantalizing anal itching which continues to plague mankind. So, we take another "new" look at the treatment of pruritus ani. Perhaps with more public education, we might even help to prevent it or to minimize its effects.

After scoping the historical past and probing the many various remedies, one finds that the common denominator of all treatments is the encouragement of the patient to take better than ordinary care of his anorectum. Because better care reduces anal itching, one might conclude that diligent, intelligent anal hygiene might prevent pruritus ani.

The diagnosis of pruritus ani is easy. The patient says, "I itch!" Then the patient will indicate the general area by employing a family code term to evade mentioning by name the anal region. Many euphemisms for the anal area exist within our pluralistic society.

Although the diagnosis of pruritus ani is easy, the treatment may not be. Many cases will get well with self treatment. Many cases will clear up when the cause is found and treated; i.e., anal warts, fissures, fistula, hemorrhoids, rectal prolapse, fungal infection, parasites, allergic contact dermatitis, etc. Too often psoriasis, a common disorder, is not considered. But there exists a considerable number of patients whose itching continues to defy remedy after remedy after remedy.

MANAGEMENT

Satisfactory results depend upon the patient's cooperative attitude and compliance with instructions. This is essential. If the patient does not faithfully follow the physician's instructions, one

can predict unsatisfactory response to treatment. Foremost in treatment of pruritus ani is getting the patient to follow instructions not only when the area itches but also when well. This is necessary to prevent relapse, often more difficult to treat than the earliest episode.

At the initial consultation, I impress, or try to impress, the patient that the itching may be chronic and recurrent, that the treatment may take a long time measured in months or years, and that the itching can recur. This discussion is necessary to erase the patient's expectation of an immediate magic cure. I don't want the patient, after obtaining early relief, to think his condition has been cured permanently. The aim of treatment is to relieve symptoms and, also, to prevent relapse. Not all cases of pruritus ani are chronic but since no one can predict which case will get well quick and stay well, the wise physician will emphasize that the itching may recur if treatment is stopped too soon. This will enable the physician to exert leverage to encourage the patient to develop and maintain good anal hygiene habits, thereby forestalling a possible relapse.

At the initial consultation, I give high priority to soliciting the patient's understanding and cooperation. Unless this is obtained, the chances for a successful result will be reduced. I tell the patient that normal skin is not likely to have a chronic itch, but skin that has been damaged by chronic rubbing and scratching will itch. As an illustrative analogy, I remark that sunburned skin takes months for the redness or bronze to return to normal color. I state that red or bronze color of the perianal area will return to original color if the area is not harmed by rubbing or scratching.

A search for the cause of itching should be made. Sometimes the cause is found, sometimes not.

SPECIFIC INSTRUCTIONS

For moderate or severe cases of pruritus ani, or anusitis if the epithelium is reddened or inflamed, here are some instructions that my patients have found helpful.

Avoid dry paper. Use cotton and water, warm then cold water. Blot! Don't rub. When only toilet

* 103 Rutledge Avenue, Charleston, S. C. 29401.

paper is available, fold, wet and blot with it.

For those who have itching after bowel movements or from seepage late in the afternoon, I suggest a "rectal gargle." Following defecation, use a three to six ounce bulb syringe with first warm water inside and outside, then simply cold water. This promotes good anal hygiene by diluting or removing the offending agents which initiated and perpetuated the chronic itch. Irrigation of the anorectum is not a new idea.

I prefer Lida Mantle-HC (Dome), which combines hydrocortisone and lidocaine three percent, in an acid mantle base, to be applied with finger three times a day.

For those who have nightly itching which keeps them awake or awakens them, I prescribe Dalmane 15 mg or 30 mg. I avoid barbiturates because of the addiction danger.

To prevent relapse, I urge the continuation of treatment for at least six months after itching has ceased. Sometimes, if the patient has had pruritus ani for many years, I think it wise to continue treatment for at least a year preferably longer. Always, I stress the need for continuing anal hygiene for the rest of their lives.

DISCUSSION

Because there are no objective parameters for judging results of treatment, the evaluation of treatment of pruritus ani continues to be difficult. There exist no "itchometers." In lieu of such mechanisms I ask the patient to discuss the degree of itching in numbers using the scale of zero to ten.

Many unanswered questions about pruritus exist. Why do some people have pruritus and others do not? What specific bacteria, enzymes, acids or other fecal elements are responsible for causing and promoting the itch?

Can pruritus be prevented? Yes, by practicing better anal hygiene. If anal hygiene can cure many cases of pruritus ani then it can prevent it.

Many physicians continue to neglect instruct-

ing their patients on anal hygiene. At the other end of the alimentary tract, the dentists have stressed oral hygiene to prevent tooth decay and gum disorders. By promoting anal hygiene physicians have the chance to practice "preventive proctology," i.e., the prevention of pruritus ani, a disorder that has continued to annoy people throughout the centuries.

The debate continues. What is the best way to clean the anal area after bowel movements? Rubbing with dry toilet paper leaves a lot to be desired. Moreover, toilet paper comes in a range of grades from paper towel to wax paper. Wet paper cleans ever so much better than dry paper. Blotting, not rubbing with its grinding effects, should be stressed.

In other cultures, the bidet is a common fixture. Dunking the bottom in water cleans ever so much better than dry paper.

Another idea being advanced to promote better cleaning is the application of lotions or emollients to the toilet paper. These may be compared to putting toothpaste on a toothbrush. They offer promise because they do make the person more concerned with the care of his anal region.

SUMMARY

Pruritus ani has been annoying people for millennia.

Many cases have been helped by the regimen presented. And some cases have had recurrences.

This modern generation has inherited an ancient malady which still defies a dependable cure. Until diseases of the anorectum can be openly discussed without embarrassment or ridicule, we will find it difficult to come to grips with the perplexing and elusive puzzle of pruritus ani and will continue merely to scratch the surface. □

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Editorial

PRESIDENTS, A PROMINENT PERFORMER, AND PUBLICISTS

The July, 1985, issue of *The Journal of the South Carolina Medical Association* was intended to cultivate and to promote interest in rectal and colonic diseases within the medical profession. However, copies of this issue were distributed a week or so after President Reagan's operation for removal of a cancerous colonic polyp, after the newspapers, television, radio, and news magazines had written and spoken extensively about symptoms, diagnosis, and treatment of colonic polyps and cancer. The media reported the clinical and pathologic data in a better way, enlightening and educating not only health workers but the public as well.

In my article, "Negative Cultural Attitudes: Their Retarding Effect on Proctology," then I wrote "This generation of physicians should recognize that inherited cultural attitudes have retarded the management of anorectal and colonic disease. We also need to recognize that cultural attitudes can be changed by physicians, other health professionals, and educators." To update my remarks, the President of the United States has done more to promote understanding and attitudinal change towards colonic polyps and colonic cancer than has any other person to date.

Since the announcement last year of President Reagan's proctosigmoidoscopy and this year's colonoscopy, there has been a groundswell of interest in bowel disorders. This has been attested by an increase in the number of phone calls and appointments made by those suddenly concerned with their gut. This rising interest is good because it can bring in more cases of early rectal and colonic cancer for treatment. Already it has.

A week or so after the news broke about President Reagan's colonic cancerous tumor, the media flashed news about Rock Hudson being an AIDS

victim. Since then there has been an upsurge of interest in acquired immune deficiency syndrome enough to become the lead story for news magazines. That Rock Hudson has AIDS has advanced interest in that disease more than any other previous word about this debilitating illness.

Contrast this with the news that President Jimmy Carter suffered from hemorrhoidal disease. To stimulate interest in research in anorectal diseases in a letter to the *New England Journal of Medicine* (April 5, 1979) about President Carter's problem, I wrote "It is time for enlightened physicians and citizens to attempt to change the public's attitude toward hemorrhoids and other anorectal diseases and to promote research for the cause and prevention of hemorrhoidal disease." The one and only letter of response came from Dr. Claude E. Welch, who had served with me on the Food and Drug Administration Advisory Panel on Hemorrhoidal Drugs, the first time the United States Government spent money to study drugs relating to anorectal diseases.

By way of comparison, a fistulectomy performed on Louis XIV of France did much to raise the status of French surgery to a position equal to that of medicine. That operation became immediately "fashionable" and many French persons showed more interest in that area of the body than ever before.

While physicians and other health workers can help promote interest and research in rectal and colonic diseases, recent events have shown that a well-known individual willing to discuss an illness of the colon can do even more.

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LETTERS TO THE EDITOR

To the Editor:

On Sunday, May 26, *The State* newspaper printed an investigative report concerning hazardous waste at Pinewood, South Carolina. The reporter, Charles Pope, is to be commended for his discerning report entitled "What's in Pinewood Landfill?" The citizens of Sumter and Clarendon counties are close to the problem; and they are certain to feel gratitude to this newspaper and a sense of relief that someone is listening. Through efforts such as these, it is the citizens of our state who will ultimately recognize the burden that has been placed upon South Carolina, on the banks of Lake Marion.

The dump is not at Pinewood, South Carolina. It literally is at Lake Marion. Though difficult to believe, the dump is really only about 400 yards from the lake, one of South Carolina's most treasured wildlife and recreational resources. Why not call the dump "Lake Marion Landfill?" More alarming, this landfill sits roughly 10 feet above the very aquifer which flows directly into the lake; and it sits only several hundred feet above aquifers from which many people drink and from which many farmers irrigate. The map provided is a fair attempt to depict the problem. However, the landfills would be more appropriately represented by a blot immediately adjacent to this vast lake, whose water flows to Charleston and to points north of it on the coast.

This landfill, as all landfills, is certain to leak one day. Common sense tells us this, and the Environmental Protection Agency agrees. DHEC has struggled with this problem and will continue to apply the law, but no landfill is "secure"; and no landfill for hazardous waste is the "state of the art." None. There is no proven way to clean up a polluted aquifer. In fact, the "state of the art" says that landfilling of hazardous waste is wrong; and most states are making it illegal. But South Carolina is still accepting the burden of wastes from many of these same states. We are accepting wastes from some 26 states and have been depositing waste at Lake Marion for the past seven years. We are told that this is necessary for a variety of ill-conceived reasons, all of which evade the basic problems at hand. These are: (1) should we bury anyone else's wastes, (2) should we store anything

hazardous under the ground, on top of our water and immediately adjacent to Lake Marion? Some would say that the answers to these questions are yes. This would motivate them to allow this burden to grow, a growth that would eventually become uncontrollable, indeed perhaps terminal.

The list of hazardous wastes provided in the article would appear to be that of the South Carolina Department of Health and Environmental Control, Bureau of Solid and Hazardous Wastes Report dated April 12, 1985. The article in *The State* did not include the following from this report. Three hundred thirty-two tons of hazardous waste came from Alabama. This state has the largest hazardous waste dump (2,400 acres) in the nation at Emelle, Alabama. That landfill is now said by EPA to be leaking. But earlier it was also referred to as the "state of the art," safe for thousands of years. It was begun one year before the landfill on Lake Marion, in 1977. Fifty-eight tons came from land-rich arid and barren Nevada, 2,000 miles away. Forty-six tons came from Puerto Rico. Three hundred ninety-eight tons came from New York. Needless to say, the amount of hazardous waste shipped these long distances, though being relatively small, probably represents what these places refused to accept as too dangerous. And why should we? Neither the report nor the article clarified what was accepted from these distant places. One cannot safely eat fish or waterfowl from many bodies of water in New York. It takes little imagination to wonder what they are sending to the banks of Lake Marion, and to the people of South Carolina.

The article also does not mention that 5.2 million pounds of acutely hazardous wastes were buried in the first six months of 1984, and that all of this came from out of South Carolina. The article does not mention the 2.6 million pounds of Beryllium dust buried in the same six months or where it came from. Is this not considered hazardous? Beryllium dust may be important to the aerospace industry and as a source of neutrons, but it is widely accepted as a source of cancer of the lung as well. There are no air pollution monitors for our landfill at Lake Marion, and this may be precisely the danger with Beryllium dust and other waste. The article could not mention the

deposit in 1985 of neutralized military hallucinogen called BZ, produced for the Army some 20 years ago for use against an enemy and stored in North Carolina while North Carolina officials looked for the "state of least resistance" and a place to receive it. The "state of the art" dump on Lake Marion received an installment, "neutralized," but too dangerous for the people of North Carolina, though much more remains in North Carolina. The article does not mention the 180 tons of cyanide compounds stored next to Lake Marion in 1984, or where they came from. Are we the enemy? The 38,882 tons of miscellaneous hazardous waste buried from South Carolina sources could not possibly warrant the attached burden of any of this to ourselves or to our posterity.

Those that would support a landfill such as that on Lake Marion as necessary would also have to argue that it is necessary to endanger the lake and everything downstream, including Charleston and points north to likely include the estuaries of Cape Romain National Wildlife Refuge. If they could justify such an argument, it would be impossible, with "state of the art" knowledge, and with what we know about the site on Lake Marion, to argue further that this dump should be adjacent to a lake as vast as Lake Marion. Neither can they argue that we know that aquifers of water below are safe, or that we know that one of those estimated 10,000 18-wheeler trucks crossing our state annually from out of state, en route to the dump, delivering some 400,000 pounds of waste a day, will not leak or have an accident polluting some other county. No one can ensure any of this and therefore no county in this state is insulated from the problem. The small end of the national hazardous waste funnel is pointed at South Carolina.

The presence of this landfill at Lake Marion defies reason. Our public may have difficulty believing that this bad dream is really true, but posterity will remind us of this reality, and hopefully it will not be our children who will bear the burden, already one billion pounds, and more than South Carolina deserves.

JAMES R. INGRAM, M.D., *President*
Sumter Clarendon Medical Society
738-A W. Liberty St.
Sumter, S. C. 29150

Robert Jackson, M.D., DHEC Commissioner,

responded to Dr. Ingram's letter as follows:

To the Editor:

The issues raised by Dr. James Ingram concerning the hazardous waste landfill near Pinewood, South Carolina are similar to those the Department has addressed as it fulfills its regulatory responsibilities to ensure that the Pinewood facility is operated in a manner which protects public health and the environment.

The issue of utmost importance for any hazardous waste land disposal activity (e.g., landfill, surface impoundment, land treatment) is for the facility to be constructed and operated to minimize the possibility of leaks and to conduct a monitoring program that ensures that any releases do not go undetected. This issue has been addressed at the Pinewood facility in several ways. First, the geologic formation within which waste is buried is very impervious. Second, liner and leachate collection systems in addition to the geologic setting are utilized to further contain the waste. Third, ground and surface water monitoring is conducted regularly. Since the facility began full scale operations in April, 1978, there has been no indication of any releases from the landfill.

New land disposal initiatives have either been implemented or will be implemented in the future as a result of the federal Hazardous and Solid Waste Amendments of 1984 (HSWA). Since May 8, 1985 the disposal of bulk or non-containerized liquid hazardous waste has been prohibited. Such wastes must now be containerized or chemically solidified before disposal. Additional requirements are forthcoming concerning disposal of non-hazardous waste liquids and containerized free liquids. Also, any lateral expansion of a landfill requires the installation of at least two (2) liners and a leachate collection system above and between the liners.

Schedules were also established by HSWA which could result in the prohibition of certain hazardous wastes from land disposal. By November 8, 1986 the disposal of certain solvents and dioxins is prohibited unless the Environmental Protection Agency determines that such a prohibition is not needed to protect human health and the environment. Similar actions will follow by July 8, 1987 for certain cyanide waste, metal contaminated waste, acid waste, PCB's, and

halogenated organic compounds. Further evaluation of land disposal methods on all listed waste not previously addressed are also required within specified time frames. Some of the wastes mentioned above are not presently being accepted for disposal at the Pinewood facility. For example, PCB's, dioxins and wastes containing high concentrations of cyanides are not accepted for disposal.

I agree with Dr. Ingram that South Carolina is sharing an unfair portion of responsibility for disposal of hazardous waste from other states. Unfortunately, the Environmental Protection Agency and the courts have taken the position that to restrict waste on the basis of origin is unconstitutional. This has resulted in South Carolina becoming an unwilling host state in its efforts to ensure safe disposal of its own hazardous waste. The solution to this problem appears to rest with the U. S. Congress to provide a state such as ours more control over commercial facilities, provide incentives to encourage other states to site disposal facilities, and encourage treatment alternatives to land disposal such as incineration.

Some wastes received by the Pinewood facility consist of large amounts of non-hazardous waste which have been contaminated with small amounts of hazardous waste constituents. Usually it is not practical or possible to separate the hazardous portion from the non-hazardous portion so it must all be handled as a hazardous waste. The resulting mixture gives an inaccurate picture of the amount of the hazardous constituent which is actually present. Contaminated soils/absorbents resulting from spills of hazardous materials and demolition debris are two waste categories where this situation is quite common. Non-hazardous wastes are also received at the Pinewood facility because the generator chooses to handle these wastes as hazardous wastes to ensure environmentally secure disposal at considerable additional cost to the industry. Such wastes could legally be disposed of in a sanitary landfill or other less secure facility. The Department does not intend to understate the fact that large amounts of truly hazardous wastes are disposed of at this facility but it should be noted that the total quantity of waste handled can be misleading as to the actual amount of toxic material present and the fact that some wastes received at the Pinewood facility are not hazardous.

Although the Pinewood disposal facility is lo-

cated approximately one-fourth ($\frac{1}{4}$) mile from Lake Marion, the landfill does not present a threat to the lake, to the environment in general or to human health. The safeguards which are built into the facility represent current technology which would provide advance warning and opportunity for corrective action for any situation which could have potential for harm. If facilities such as the Pinewood facility are not available to properly dispose of the hazardous wastes generated from the manufacture of products which our society demands, the improper dumping of these wastes along the roadsides, in our lakes and streams and in substandard facilities would pollute our air, water and land with significant adverse human health and environmental consequences.

ROBERT S. JACKSON, M.D., *Commissioner*
S. C. Department of Health and
Environmental Control
2600 Bull St.
Columbia, S. C. 29201

To the Editor:

I read "An Historical Sketch of Proctology From Ancient Egypt to Modern South Carolina" (July 1985) with interest and must observe a serious void in the omission of an outstanding pioneer in the specialty of proctology in South Carolina; Dr. Benjamin Rubinowitz.

My brother, Dr. Rubinowitz, was a graduate of the Medical College of South Carolina, class of 1929. His earliest introduction to the surgery of proctology was in his assisting Dr. Frank Durham. Following Dr. Durham's untimely death, Dr. Rubinowitz trained at the Mayo Clinic under Dr. Buie, a native of Georgetown, S. C., who was noteworthy in establishing proctology as a specialty. After completion of his work at the Mayo Clinic, Dr. Rubinowitz returned to Columbia, S. C., and thereafter practiced proctology exclusively for approximately forty years.

Dr. Rubinowitz enjoyed a fine reputation for his excellent work in the field of proctologic surgery. He was noted for his skillful repairing of work previously done at many famous institutions, as well as his concern and devotion to his patients. His extensive practice included numerous notable South Carolinians.

Dr. Rubinowitz was a modest man not given to writing papers but rather to devoting his time to

the instruction of residents, interns, and nurses at the Columbia Hospital (Richland Memorial) in proctologic surgical skills. He personally performed the follow-up treatments which he deemed so important in alleviating undue suffering. He was proud to say that his results were his best recommendation.

Dr. Rubinowitz served as secretary of the Columbia Medical Society for many years, as well as Chief of Staff of the Columbia Hospital (Richland Memorial).

I am sorry that the article in *The Journal* failed to recognize this truly outstanding and dedicated pioneer of proctologic surgery in S. C.

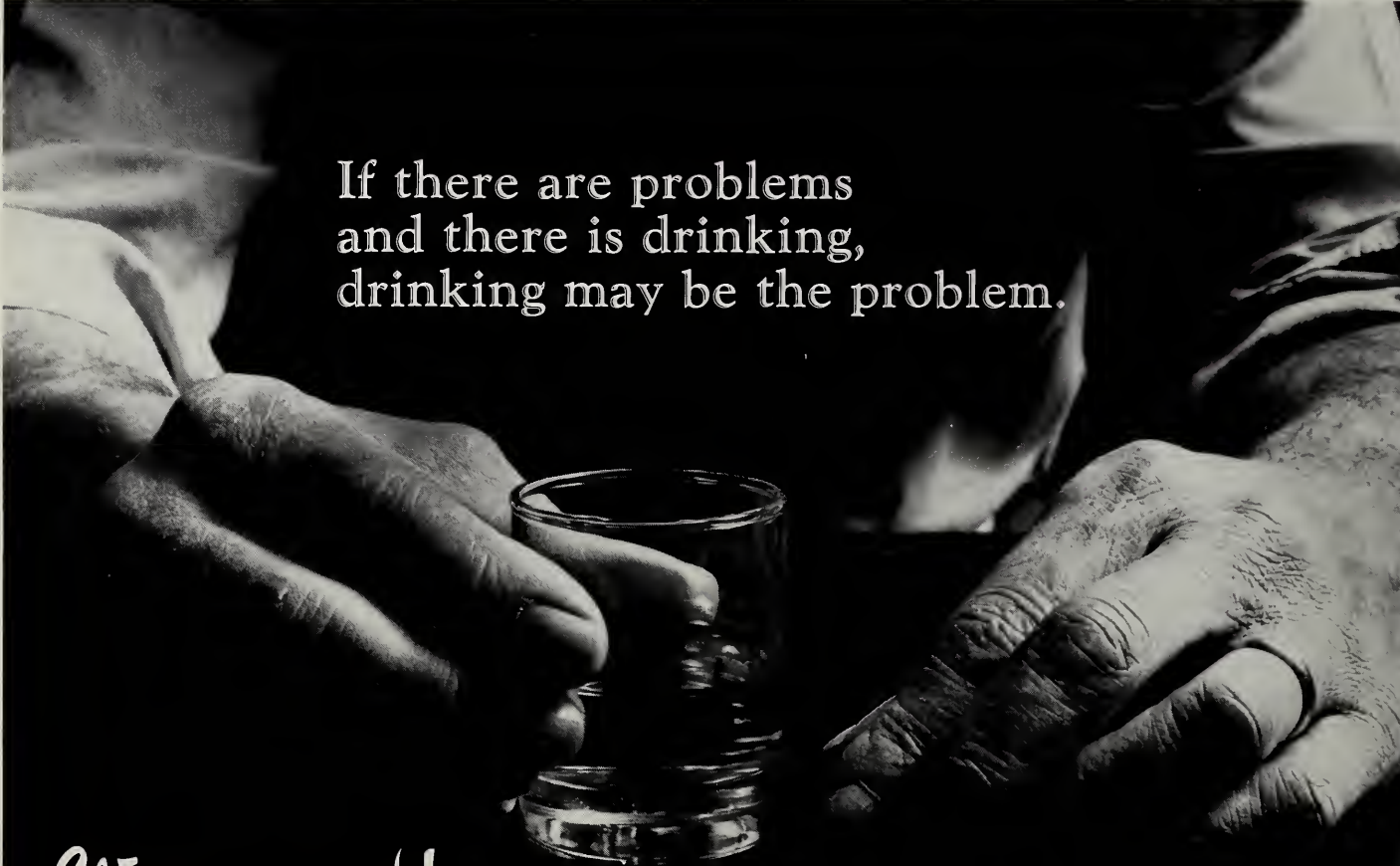
A. M. ROBINSON, M.D.
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Dr. Banov responded to Dr. Robinson's letter with the following comments:

To the Editor:

I thank Dr. A. M. Robinson for calling attention to the omission of his brother, Dr. Benjamin Rubinowitz, from the historical sketch. Because he was not a member of the American Proctologic Society nor a member of the regional Piedmont Proctologic Society, the name of Dr. Rubinowitz did not readily come to mind. I am sorry for the omission.

LEON BANOV, JR., M.D.
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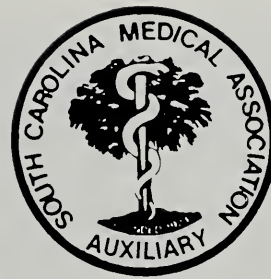


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During the past year county auxiliaries have undertaken such projects as health careers and scholarships, substance abuse education and prevention, and safety projects such as child fingerprinting and automobile safety restraints. Auxiliaries have also been active in the area of prevention of child and spouse abuse and neglect through education and shelter. They have sponsored health fairs, CPR training, screening for blood pressure and cancer and have worked to provide health care for the indigent.

Recently, our State Health Projects Committee has been assisting the Child Protection Committee in preparation for the seminar on the prevention of child abuse and neglect being held on October 3, 1985. The seminar is jointly sponsored by the SCMA and Auxiliary and Academies of Family Practice and Pediatrics.

The national focus on prenatal and postnatal care is being encouraged under the umbrella of the "Shapeup for Life" campaign. This year we are working to develop and implement a statewide program on the prevention of teenage pregnancy. We strive hard to project a positive image by stressing good health habits through this innovative AMA approved project. The enthusiasm generated by Auxilians across the state opens new doors for service and education to the people of South Carolina.

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President's Page

A LETTER TO A FRIEND



Dear John:

I really enjoyed that last letter from you, and the correspondence we've had together since our days in medical school have always been a joy. They always remind me of some incident during our training which reflects the carefree joy with which we approached life.

Since then we have gone our separate ways, though our basic philosophy has remained the same — the main difference being that you elected to practice good medicine, be a good father and leave the politics of medicine alone.

Life was so simple through medical school and training, and the anticipation of seeing patients, helping patients and having a good life for the family seemed automatically ahead.

It didn't seem to matter where we chose to practice only that we found a place which suited our expertise, did a good job and all the rest would fall into place. The restless ambition of youth swelled over the small obstacles in our way and we knew we could do it.

Well, some big changes have occurred since then. I need you now worse than I have ever needed you before, and the profession needs you. It's time for you to rejoin those who have walked the halls of Legislature. It's time for you to give some of your energies to the generations of physicians to come. You and I inherited a lot from those before us and if we aren't careful and strong, those coming behind us will not know these joys.

The pressures on the general field of medicine today are horrendous. I know I sit and listen to those who think they know how to run our profession better than we do. There are some critical issues at hand and I want you to stand up with me.

I found that each year has its quest. The biggest quest this year is Tort Reform. You may be one of the one out of four physicians in South Carolina who has had dealings with malpractice this year. The laws governing Tort Reform in this state are sort of behind the times and really need revising. We don't need an advantageous position, but we are due a fair shake and with your help we can restore some fairness into the present system.

There's also the great pressures of corporate management of physicians. These have surfaced under many health delivery schemes and various health insurance proposals. You and I need to stand together to filter out through the screen of quality medicine what will be best for ourselves and our patients. I need your thoughts and your actions.

Florence and I send our regards to your family and children and look forward to seeing you at our next reunion. How you and I react between now and then to the pressures around us will govern the happiness that we see at that next reunion. So get yourself ready. I look forward to having you standing by my side as we meet these problems, and I know you'll be there. By the way, I still have those old Phi Chi pictures you never would show Sue.

Your friend,

A large, fluid, handwritten signature in dark ink, appearing to read "J. G. Appleby".

GAVIN APPLEBY



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INFORMATION FOR AUTHORS

Authors should refer to the detailed instructions in the January issue. Manuscripts and other correspondence should be addressed: The Editor, JOURNAL OF THE SOUTH CAROLINA MEDICAL ASSOCIATION, Post Office Box 11188, Columbia, S. C. 29211.

All manuscripts should be accompanied by a transmittal letter with the following paragraph: "This original work has not been submitted or published elsewhere, in entirety or in part. I (we) hereby transfer, assign, or otherwise convey all copyright ownership to the South Carolina Medical Association in the event that this work is published by the SCMA."

We request that manuscripts be concise (no longer than 8 typewritten pages, double-spaced), with no more than ten references. These should be cited in the text in superscript, e.g., "Bottsford, et al.³", and should conform to the following style: "3. Bottsford JE, Bearden RC, Bottsford JG: A ten year community hospital experience with abdominal aorta aneurysms. *J S C Med Assoc* 79: 57-62, 1983." Ordinarily, publication of four small illustrations or tables or the equivalent will be paid for by *The Journal*. Manuscripts should be submitted in duplicate. Reprints will be made available by the publisher.



MANAGEMENT OF PANCREATIC PSEUDOCYSTS

MARION C. ANDERSON, M.D.*

Pancreatic pseudocysts represent one of the major complications of pancreatic inflammatory disease. The purpose of this presentation is to provide an overview of the problem based upon an update and distillation of information developed several years ago for a chapter in the *Second Edition of Diseases of the Pancreas* edited by Howard, Jordan and Reber.¹ The observations included in this review are based upon a personal experience in the management of 100 patients with a total of 112 pseudocysts, along with a review of the world literature.

ASSOCIATED DISEASES

A high proportion of pseudocysts develop in the patient with chronic pancreatitis associated with alcohol abuse. In our series approximately 80 percent fell into this category. The second most common cause was biliary-induced pancreatitis (8%), followed by pancreatic trauma (6%). Other less common causes include pancreatic cancer, hyperlipidemia, hereditary and drug-induced pancreatitis. Rare causes include pancreatitis secondary to transplantation, hyperparathyroidism and heat stroke.

CLINICAL PRESENTATION

Pseudocysts may develop in the course of an attack of acute pancreatitis when a tender upper abdominal mass becomes apparent during the recovery phase. Under these circumstances the date of origin can be estimated with reasonable accuracy. In other cases the patient presents with

an upper abdominal mass in association with findings compatible with chronic pancreatitis. When the latter is advanced there may be associated malnutrition, diabetes and malabsorption. Under these circumstances estimation of the duration of the cyst may be difficult or impossible.

LABORATORY FINDINGS

The most consistent laboratory abnormality is an elevated serum amylase. Jaundice may occur and suggests distal biliary obstruction either by a cyst in the head of the gland or secondary to the underlying chronic pancreatitis.

RADIOGRAPHIC FINDINGS

Recent developments in the field of radiology have greatly enhanced preoperative assessment of pancreatic disease, including pseudocysts. An upper gastrointestinal series may show displacement of adjacent organs by the pseudocyst (Fig. 1). Demonstration of pancreatic and biliary ducts with endoscopic retrograde cholangiography and pancreatography (ERCP) provides important information regarding the underlying pancreatic pathology (Fig. 2). In most cases the pancreatic ducts are involved by one or more strictures with associated ductal dilatation and calculus formation. The terminal common bile duct also becomes involved in the chronic inflammatory process as it passes through the head of the gland, and results in a long "rat-tail" stenosis.

CT scans have provided a very sensitive diagnostic modality for assessment of location, size and maturity of the cyst (Fig. 3). Current generations of CT scanners afford excellent delineation of duct size. Dilatation of the extrahepatic and intrahepatic ducts also can be accurately defined.

* Department of Surgery, Medical University of South Carolina, 171 Ashley Avenue, Charleston, S. C. 29425.

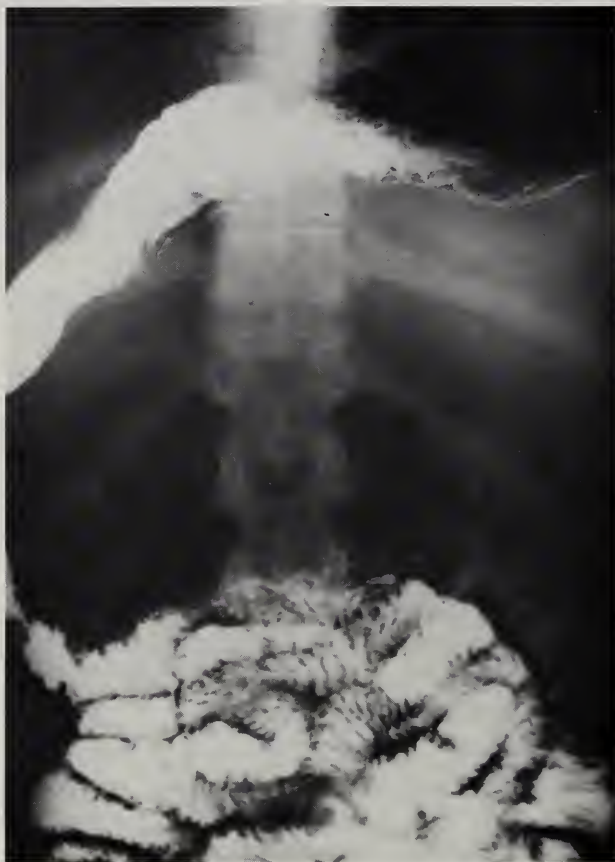


FIGURE 1. Upper gastrointestinal series showing marked displacement of the stomach superiorly and widening of duodenal sweep by single pseudocyst which contained three liters of fluid.



FIGURE 2. ERCP showing characteristic ductal changes in chronic fibrocalcific pancreatitis. There is a long "rat tail" stenosis of the terminal common duct (large arrow). The pancreatic duct (Wirsung) is dilated with ectasia of the side branches and contains multiple calculi (small arrow).

When image enhancement with an intravenous contrast agent is employed the vascular supply of the pancreas can be identified.

Ultrasound is also an effective and less expensive method for localizing pseudocysts, demonstration of gallstones and dilatation of extra and intrahepatic ducts. Overall the precision of the CT scan in providing detailed information has made it the definitive examination in our hands.

Selective celiac and superior mesenteric angiography are usually unnecessary in the routine assessment of pancreatic pseudocysts. Angiography is extremely valuable in evaluating complications which involve the vascular supply of the pancreas such as erosion of major arteries and identification of the patient with splenic vein thrombosis and left-sided portal hypertension (Fig. 4). Recently digital subtraction angiography and image enhanced CT scans have provided additional and potentially less threatening methods for evaluation of these patients.

NON-OPERATIVE (MEDICAL) MANAGEMENT

Approximately 20 percent of pseudocysts resolve spontaneously. These usually develop during an acute attack of pancreatitis (acute cysts) and follow-up with ultra-sound or CT scans will demonstrate disappearance, usually within six weeks following the attack.

In most cases a six-week period of observation is indicated to permit resolution of acute cysts and to afford time for the cyst wall to mature into a firm fibrous structure capable of holding sutures at the time of internal drainage. When estimation of cyst age is not possible, the CT scan provides information regarding the thickness and density of the wall (Fig. 3). Bradley and Associates² have shown that when cyst decompression is delayed beyond six weeks the number of major complications, such as intraperitoneal rupture and erosion into adjacent viscera, increase.

During the observation period much can be accomplished to improve the patient's condition and thereby reduce the risk of postoperative complications. Many of these patients are malnourished and benefit from total parenteral nutrition. Diabetes also should be brought under control and other underlying medical problems addressed.

During the period of conservative management the patient must be carefully observed for increas-



FIGURE 3. CT scan showing the mature thick-walled pseudocyst originating from the head of the pancreas. The pancreatic duct (Wirsung) is dilated and contains two large stones in the proximal duct as well as smaller stones in the body and tail of the gland (arrows).

ing symptoms or signs. Persistent pain and tenderness, fever and leukocytosis may indicate progression, cyst infection or conversion to pancreatic abscess. The latter requires urgent drainage.

There is increasing interest in the initial management of large pseudocysts, infected pseudocysts and pancreatic abscess with CT guided percutaneous catheters.³ Failure to promptly improve following stent placement signals the need for immediate surgical decompression.

SURGICAL MANAGEMENT

The surgical approach to a pancreatic pseudocyst varies depending on a number of factors, including the underlying cause, the size, location and the maturity of the cyst wall. Whenever possible, the status of the pancreatic ducts should be assessed either preoperatively with ERCP or with intraoperative pancreatography. When the characteristic ductal strictures and associated segmental sacculation (chain of lakes) are demonstrated, a lateral pancreaticojejunostomy is indicated to decompress the obstructed ductal system whenever technically feasible.

Drainage procedures. Large cysts usually originate from the anterior surface of the body of the gland. Because of their size and associated inflammatory reaction the operative procedure must be limited to decompression with either external or internal drainage.

External drainage is employed in instances where the cyst wall is considered to be immature

and inadequate to hold sutures. Also, in cases where the cyst has become infected external drainage with a large bore soft sump catheter (Chaffin Tube) is the procedure of choice. The catheter should be fixed in place with a purse string of non-absorbable suture and brought to the exterior through a separate stab wound. External drainage may be life-saving when the cyst is infected. Disadvantages include the likelihood of a pancreatic fistula which usually will close spontaneously. Also the recurrence rate following external drainage is substantial. Finally, external drainage is known to carry a high mortality rate because of its use in poor risk patients with complicated problems.

Internal drainage is employed to decompress large non-infected pseudocysts. Establishment of a direct communication between the cyst and the adjacent stomach (cystogastrostomy) or duodenum (cystoduodenostomy) are the most common methods. Both procedures carry a low mortality and the early recurrence rate is minimal. Sutures used to establish the communication should be non-absorbable since absorbable sutures are rapidly digested by pancreatic enzymes. All bleeding points must be meticulously controlled to avoid the most common postoperative complication — bleeding from the stoma site.

Cystojejunostomy also has been utilized with decompression into a Roux-en-Y limb of jejunum.



FIGURE 4. Venous phase of a celiac arteriogram. There are large varices in the gastric fundus. The splenic vein is compressed by a large pseudocyst in the pancreatic tail (arrows). Patient later developed complete splenic vein occlusion requiring distal pancreatectomy and splenectomy. Splenic artery inflow was controlled with a balloon catheter placed prior to operation.

Satisfactory resolution of the cyst can be achieved with this method; however, it is a more extensive operation. In addition, a Roux limb of jejunum may be required at a later time to provide definitive ductal compression with lateral pancreaticojejunostomy. It is for this reason that the author rarely uses this technique to drain a pseudocyst.

In the occasional patient who develops a pseudocyst consequent to biliary pancreatitis, internal drainage of the cyst combined with comprehensive eradication of biliary calculi is almost always curative.

Pancreatic resection. Distal resection is employed most frequently for small cysts (6 cm or less) located in the tail of the gland. Such cysts are difficult to drain internally and frequently are intimately related to the splenic hilum. A number of cases of massive bleeding consequent to splenic erosion have been reported.⁴ In addition to the distal resection many of these patients require a lateral pancreaticojejunostomy to decompress the remainder of the pancreatic duct. Also, splenectomy is necessary when distal pancreatectomy is employed and these patients should receive appropriate prophylaxis to avoid postoperative infection.

The author has postulated that small cysts originating in the superior aspect of the head of the gland develop as a consequence of obstruction involving the duct of Santorini.⁵ To date a total of 32 patients have been managed with this problem. Early in the series we employed cystoduodenostomy to decompress the cyst, along with lateral pancreaticojejunostomy for ductal decompression. More recently we have drained the cyst directly into the lateral pancreaticojejunostomy. This avoids the need to perform a duodenotomy.

Although some authors have advocated pancreaticoduodenectomy for management of cystic lesions in the head of the pancreas, the author regards this as an unnecessarily radical approach. The problem can be successfully managed in nearly all cases with retrograde drainage techniques.

COMPLICATIONS

Complications involving the pseudocyst:

Occasionally a pseudocyst will become infected and progress to abscess formation. The clinical course is characterized by increasing pain, tenderness, fever and leukocytosis. Prompt external

drainage is mandatory. At present percutaneous CT guided stent drainage of pancreatic abscess is under evaluation.³ Failure to promptly bring sepsis under control is an indication for urgent operative decompression of the area; mortality approximates 100 percent in cases inadequately treated.⁶

Spontaneous rupture of pseudocysts has a reported mortality in the range of 50 percent. This suggests that many of these cysts were infected.

Complications Involving Adjacent Organs:

Gastrointestinal tract. Because of the intimate relationship of the pancreas to the intestinal tract, pseudocysts often become adherent to adjacent organs including the stomach, duodenum, jejunum and transverse colon. The associated inflammatory reaction may result in partial and even complete obstruction. Cysts also may erode into a segment of bowel producing a cystenteric fistula and spontaneous internal drainage.⁷

Biliary tract: As indicated above, the terminal biliary tract may become stenotic as a consequence of the inflammatory process in the head of the pancreas.⁸ This is usually a long, tapering (rat-tail) stenosis rather than the abrupt, complete occlusion which characterizes extrahepatic obstruction secondary to carcinoma. Simple decompression of a cyst in the pancreatic head may not relieve the common duct stenosis which may result from the underlying chronic inflammation in the pancreas. Biliary by-pass with choledochoduodenostomy or cholecystoduodenostomy is indicated in patients with jaundice to prevent recurrent bouts of cholangitis and progressive biliary cirrhosis.

Genitourinary tract: Pseudocysts located in the head and tail of the gland may involve the kidneys with resulting stricture of the renal pelvis and even cystoureteral fistulae. Occasionally cysts erode through Gerota's fascia and produce a perinephric fluid collection.⁹

Diaphragm and chest: Pseudocysts may extend upward into the mediastinum through the aortic or esophageal hiatus. Erosion into the pleural space results in pancreatopleural fistula with massive pleural effusion containing high levels of amylase and protein.

Arterial complications: A number of important arteries are closely related anatomically to the pancreas. When these vessels become incorporated into the inflammatory wall of a pseudocyst,

erosion may occur with formation of a pseudoaneurysm or complete disruption.¹⁰ Clearly this is the most formidable and life-threatening complication associated with pseudocysts. Immediate splanchnic angiography is essential, and when the site of erosion can be identified several options are available. When large vessels such as the splenic artery are eroded, placement of a balloon catheter to temporarily occlude the vessel may be life-saving and provide time to approach the problem surgically. This usually involves proximal arterial control and resection of the cyst and involved distal pancreas. When smaller vessels are eroded selective placement of the catheter and embolization of the vessel can be attempted. When this fails operative control is necessary. The latter may challenge the surgical ingenuity of the most accomplished surgeon.

Venous complications: Severe chronic pancreatitis with or without pseudocysts may produce thrombosis in the tributaries of the portal vein and even the portal vein proper. Most commonly splenic vein obstruction develops and results in left-sided portal hypertension.¹ Collateral circulation develops through the short gastric veins, the venous drainage from the gastric cardia and the coronary vein. In addition, the left gastroepiploic vein usually is involved. Eventually the aforementioned vessels become massively dilated and bleeding from gastric varices may occur. Demonstration of this problem is often possible utilizing image enhancement with the CT scan. Identification of left-sided portal hypertension prior to operation is important; massive bleeding may be encountered. In recent cases placement of a balloon catheter in the splenic artery just prior to operation to control inflow to the obstructed system has been helpful. Also, in several patients the splenic artery has been embolized with autologous clot to aid in inflow control. In most instances the problem is corrected by splenectomy which permanently interrupts arterial inflow.

RESULTS

Recurrence of pseudocysts occurs in approximately 10 percent of cases following either drainage or resection. The highest recurrence rate is associated with external drainage.

Postoperative morbidity occurs in approximately one-third of cases and usually relates to pseudocysts which are involved in associated complications (see above).

The mortality also reflects the severe complications which may develop as a consequence of the pseudocyst involving adjacent organs, particularly the vascular system. In our own series mortality occurred in 15 percent of cases and emphasizes the magnitude of the problem presented by pseudocysts of the pancreas.

SUMMARY

Pancreatic pseudocysts represent a formidable surgical challenge. The diagnosis and preoperative management have been greatly improved in recent years with the introduction of sophisticated radiologic technology and the availability of total parenteral nutrition.

Most large pseudocysts are managed initially by external or internal drainage procedure. It is important to emphasize that cyst drainage does not correct the underlying ductal obstruction and chronic pancreatitis which usually is present. Lateral pancreaticojejunostomy may be required later to decompress the obstructed exocrine pancreas.

Smaller pseudocysts which occur predominantly in the head and tail of the gland can be managed either by distal resection or internal drainage combined with lateral pancreaticojejunostomy to correct underlying exocrine obstruction.

Pseudocysts may be associated with a variety of serious complications most of which involve adjacent organs. These complications contribute both to the postoperative morbidity and mortality associated with surgical management of these patients.

Additional references and tables are available from the author on request. □

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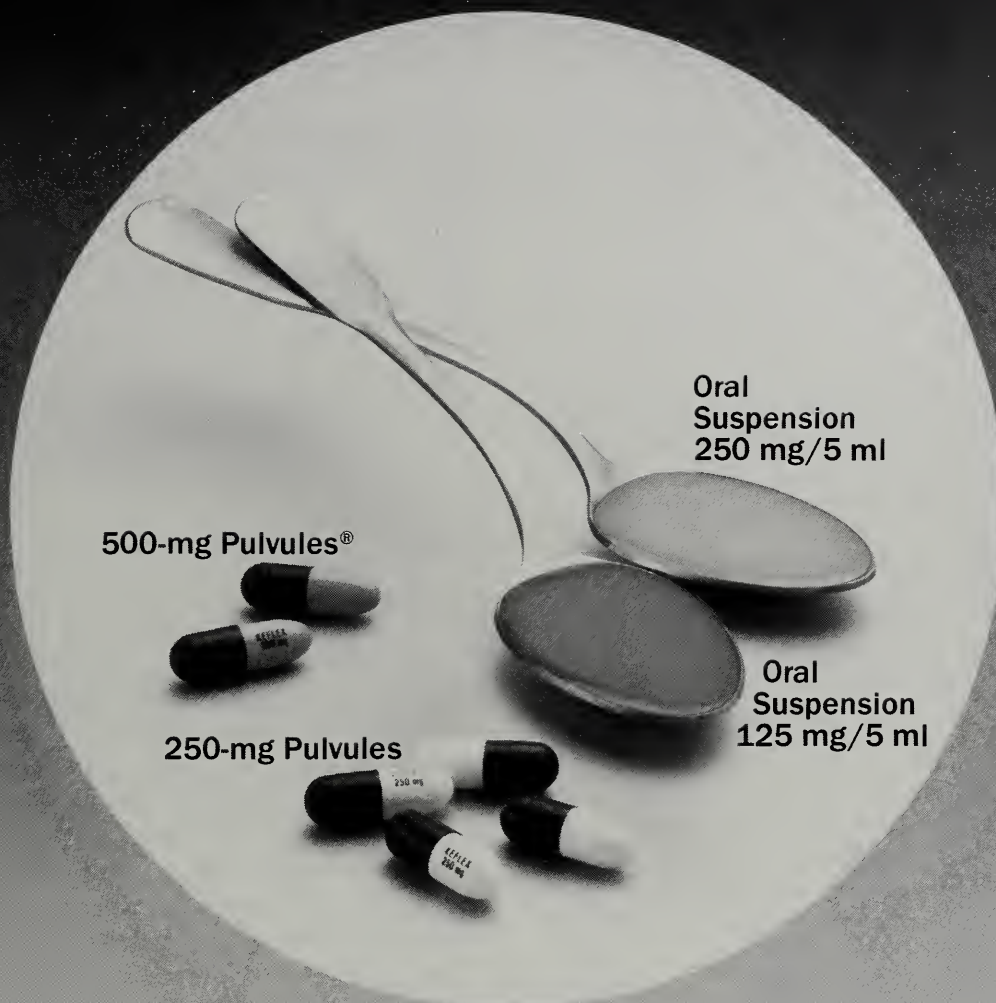
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SAFETY HELMET REPEAL AND MOTORCYCLE FATALITIES IN SOUTH CAROLINA*

TERRANCE P. McHUGH, M.D.**

JAMES I. RAYMOND, M.D.

Because most motorcycle deaths result from serious head injuries, in 1966 the Department of Transportation was empowered to withhold highway construction funds for those states not requiring the use of safety helmets.¹ In South Carolina, a law mandating the use of helmets and other safety equipment was enacted in 1967 and enforced in 1968. Following the removal of national sanctions in 1976 and subsequent lobbying by motorcycle associations, South Carolina joined many other states in repealing safety helmet requirements. As of June 17, 1980, only motorcyclists younger than 21 years of age are still required to wear helmets. Five years have passed since repeal and now accident statistics are available which show the results of this action.

METHODS

Motorcycle accident statistics over the 20-year period extending from 1965 through 1984 were obtained from the Highway Safety Division of the South Carolina Department of Highways and Public Transportation. During this 20-year period there were a total of 28,045 reported motorcycle accidents and 820 reported deaths. All motorcycle accidents were analyzed for the following: number of accidents/year; number of persons killed/year; the number of registered motorcycles/year; and the annual death rate/10,000 registered motorcycles.

RESULTS

Table 1 shows the number of motorcycle registrations and deaths for each year from 1965 to 1984. Because the number of motorcycles registered each year varies, the registration death rate is a corrected rate which allows each year to be

accurately compared to every other year included in the study.

The number of deaths has steadily increased in all but one of the years since the repeal of the safety helmet law (see Figure 1). In fact, despite a 5.7 percent decline in the registration rates for the four years preceding and subsequent to 1980 (159,593 versus 150,534), the mean registration death rate has dramatically increased during those same years (11.3 versus 18.8). Comparing the last year for which statistics are available, 1984, with the year before repeal, 1979, although the number of registered motorcycles remained approximately the same, the registration death rate increased 221 percent and the registration accident rate increased 171 percent.

DISCUSSION

Motorcycles are a popular yet dangerous form of transportation. A motorcyclist is eight times more likely to be fatally injured per mile driven than the operator of an automobile.² Motorcycles are particularly dangerous in the hands of the young. Doolittle, et al¹ state an adolescent boy has a two percent chance of being killed or seriously injured for each year he owns a motorcycle. In 1977, motorcycles accounted for only 1.5 percent of all motor vehicle accidents but were responsible for 6.1 percent of all the deaths.¹ In 1981, they were still only responsible for 1.8 percent of all accidents but 9.3 percent of fatalities; in that same year, the National Safety Council found that the nearly six million registered motorcycles in the United States accounted for 4,720 deaths and an estimated 520,000 injuries.²

McSwain and Petrucelli³ report that over 35 states have repealed or altered mandatory helmet legislation since May, 1976; in many of these states, they found a significant increase in head injuries and deaths. In comparing pre- and post-repeal accident rates in Colorado, they found that the fatal crash rate increased by 66 percent and the injury rate by 17 percent in one year. Kansas, despite a decline of four percent in registered

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SAFETY HELMET REPEAL

Motorcycle Fatalities

Table 1

<u>Year</u>	<u>Persons Killed</u>	<u>Number of Accidents</u>	<u>Motorcycle Registrations</u>	<u>Death Rate¹</u>	<u>Accident Rate²</u>
1965	13	502	7,609	17.1	6.6
1966	23	591	11,248	20.4	5.3
1967 *	10	368	11,945	8.4	3.1
1968 **	9	280	12,143	7.4	2.3
1969	9	272	12,942	7.0	2.1
1970	15	607	15,633	9.6	3.9
1971	23	907	17,870	12.9	5.1
1972	39	1,223	22,515	17.3	5.4
1973 +	50	1,958	33,268	15.0	5.9
1974	60	2,319	47,328	12.7	4.9
1975 ++	54	1,913	48,040	11.2	4.0
1976	47	1,835	45,686	10.3	4.0
1977	53	1,765	41,161	12.9	4.3
1978	38	1,561	35,280	10.8	4.4
1979	42	1,543	37,466	11.2	4.1
1980 ***	55	1,764	38,875	14.1	4.5
1981	46	1,934	42,257	10.8	4.6
1982	61	2,019	35,028	17.4	5.8
1983	81	2,091	36,130	22.0	5.8
1984	92	2,593	37,119	24.8	7.0

1. Based on 10,000 registrations.
2. Based on 100 registrations.

- * Safety equipment law enacted.
** Safety equipment law enforced.
+ "Lights on" effective July 1.
++ Classified license required for motorcycles.
*** Repeal of helmet and goggles law for age 21 and older effective June 17.

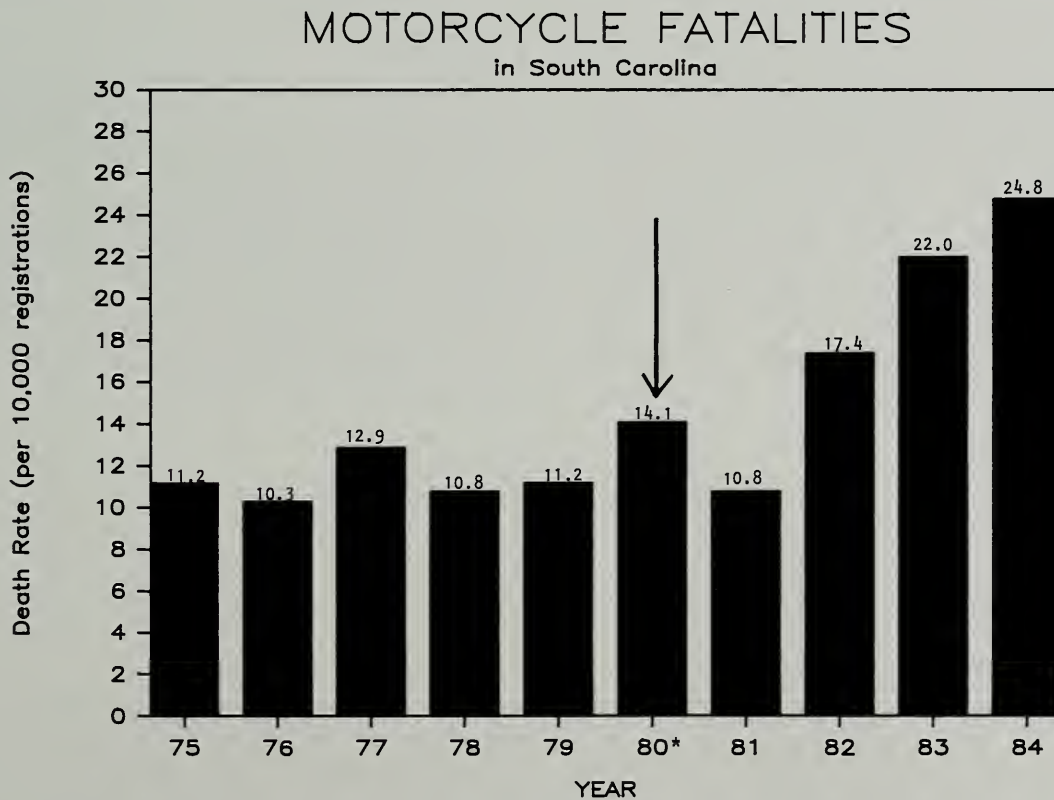


Figure 1. *Repeal of helmet and goggles law for age 21 and older effective June 17.

SAFETY HELMET REPEAL

cycles, reported a 12.3 percent increase in accidents, a 106 percent increase in head injuries, and a 63.3 percent increase in deaths in the year following repeal. Before repeal, extremity injuries exceeded head injuries; after repeal head injuries were more dominant.³ Likewise, the duration of both hospitalization and disability was significantly increased for nonhelmeted motorcyclist. McSwain reports the costs of medical care and disability are approximately 200 percent higher for nonhelmeted cyclists.³

Once motorcyclists are no longer required to wear helmets, 40 percent will stop using them, despite the fact that they are then twice as likely to suffer a serious head injury and nine times more likely to be killed by this means.⁴ Motorcyclists have traditionally been against wearing safety helmets for one or all of the following reasons: decreased vision, decreased hearing, the weight of the helmet, and the fear of increased neck injuries. Russo⁵ has rebuked all these allegations. She found full-coverage helmets account for less than a three percent loss in horizontal peripheral vision; any noise loud enough to be heard above the wind or the motorcycle itself will be heard inside a helmet; the weight of a helmet does not increase rider fatigue; and helmets do not contribute to the incidence of neck injuries. It has recently been demonstrated with fluoroscopic and radiographic techniques that forced hyperextension of the neck is not responsible for any guillotine effect causing neck injuries⁶ and McSwain's study confirmed that it was the nonhelmeted riders who actually had an increase in serious neck and face injuries.⁴

Maloney has conducted an independent investigation of motorcycle accidents in South Carolina. He found there were two main predictors of poor outcome following a motorcycle accident;

hitting a fixed object and nonuse of a safety helmet (personal communication).

CONCLUSIONS

The American Medical Association's Conference on Head Injuries has recommended that all motorcyclists should wear a full-facial-coverage, properly fitted helmet. Now that the General Assembly has enacted safety legislation requiring the use of child carseat restraints and is considering mandatory seatbelt laws as well as imposing tougher sanctions against drunk drivers, this may be an appropriate time to restudy the entire issue of motorcycle helmet usage. Until then, the best hope in preventing unnecessary motorcycle deaths remains education of those at risk, especially those young cyclists less than 21 of age who must still wear safety helmets. Proper education may convince many to continue wearing their helmets after their twenty-first birthday. □

ACKNOWLEDGEMENTS

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2. John M. Maloney, Acting Director, Division of Investigation and Control, South Carolina Department of Health and Environmental Control.

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SCMIA

NEWSLETTER

November, 1985

SCMCF CANCELS PRO CONTRACT

The South Carolina Medical Care Foundation has cancelled its Medicare review contract with the Department of Health and Human Services.

The Board of Directors of the Foundation cited "grave concerns" over HHS's administration of the Peer Review Organization program as the reason for cancellation. Current HHS demands created administrative and financial burdens that, in addition to being in violation of the original SCMCF-HHS contract, added nothing to the health care of South Carolina's elderly patients.

The Foundation's Peer Review Organization, comprised of over 2,000 South Carolina physicians, was the first PRO in the United States. It has been responsible for assuring quality of in-hospital care for all South Carolina Medicare patients. Additionally, HHS has recognized the Foundation for having the number one ranked federal review program in the country in terms of effectiveness.

The Foundation was awarded the \$3.7 million contract in July of 1984. Since that time they have reviewed some 150,000 Medicare cases under this contract. Eight of South Carolina's 73 hospitals had erroneously reported the Foundation's review decision on some of their Medicare bills. The Foundation agreed to re-submit corrected reports from the eight hospitals. However, this solution was unacceptable to HHS which insisted that cases from all 73 hospitals be reviewed again.

The concerns expressed by the Foundation's Board of Directors were that current HHS administrative demands (1) *were in violation of the SCMCF-HHS contract*; (2) *were unreasonable and unnecessary*; and (3) *would create financial and administrative burdens to the PRO if implemented*. The Foundation, therefore, concluded that cancellation of its contract was preferable to continuation under the present HHS administration of the program.

The cancellation is especially disappointing to the Foundation Board of Directors because of its history as the premiere review organization in the country and its successful review programs with private industry and the State Medicaid program. As a result of this cancellation, quality and utilization review for the elderly in South Carolina will come to a halt until HHS re-negotiates a new PRO contract in South Carolina.

The Foundation plans to continue its reviews for private industry and the State Medicaid programs. Effective with Medicaid admissions of November 18, it is necessary to call 1-800-922-6006 to obtain preadmission review for Medicaid hysterectomies, cholecystectomies, herniorrhaphies, D&C's (exclusive of D&C's for abortion), tonsillectomies/adenoidectomies, and arthroscopic knee surgeries. It is no longer required to obtain preadmission review for Medicare lens procedures, hip/knee replacements and pacemaker implants due to the PRO contract cancellation.

CARDIAC REHABILITATION PROGRAMS CERTIFIED

The South Carolina Medical Association/South Carolina Heart Association Joint Committee on Cardiac Rehabilitation, in August and September, conducted onsite certification surveys of several Cardiac Rehabilitation Programs throughout the state, and made recommendations to the SCMA Board of Trustees regarding their certification.

Granted full certification for a two-year period were (1) *Carolina Community Cardiac Rehabilitation Program*, (2) *McLeod Cardiac Rehabilitation Program*, and (3) *Spartanburg Cardiac Rehabilitation Program*. In all categories, these programs either met or exceeded standards established for certification.

Granted provisional certification was *New Life Cardiac Rehabilitation Program* in Columbia. This provisional certification allows a period of time not to exceed six months and another onsite survey within three months.

RISK MANAGEMENT COMMITTEE DEFENSE ASSISTANCE PROGRAM

The Risk Management Sub-Committee of the Professional Liability Committee, chaired by *Euta M. Colvin, M. D.*, is establishing a program to improve on the defense of damaged baby cases which are becoming increasingly more prevalent in South Carolina.

Funded by the JUA and administered by the SCMA, the program would:

1. Expand upon the current plaintiff expert witness index by including trial reports from defense attorneys as well as any other information that can be obtained through active research of each individual. CV's on each expert would be developed and made available.
2. Establish specialty panels of experts to review cases with attorneys prior to trial.
3. Identify physicians who could serve as effective defense experts.
4. Establish a Trial Resource Center which would keep on file judges' orders, briefs that have been filed, attorneys involved, etc. This center would act as an Information Resource Clearinghouse.
5. Join the Defense Research Institute to gain access to the information available from that source.

DUNCAN ELECTED TO FILL VACANT AMA ALTERNATE DELEGATE SLOT

As authorized by the SCMA Constitution and Bylaws, the SCMA Board of Directors, on October 17, held an election to fill the vacancy in the position of AMA Alternate Delegate, formerly held by the late Leonard W. Douglas, M. D.

Charles R. Duncan, Jr., M. D., a Greenville Ophthalmologist, was elected to the vacancy to serve until a regular election can be held at the 1986 Annual Meeting. Dr. Duncan is currently Chairman of the SCMA Board of Trustees and President of the S. C. Society of Ophthalmology.

CAPSULES...

...Robert H. Taylor, M. D., of Spartanburg, was elected President-Elect of the American Academy of Family Physicians at its October meeting in Anaheim, California.

...The SCMA Board of Directors has approved honorary membership status for Barney F. Timmons, M. D., Frank P. Gaston, M. D., and Frank S. Fairey, M. D.

CALL FOR ABSTRACTS FOR AMSAODD AND RSA MEETING

The American Medical Society on Alcoholism and Other Drug Dependencies (AMSAODD) and the Research Society on Alcoholism (RSA) will hold a joint meeting in San Francisco from April 18 to 22, 1986, at the Westin St. Francis Hotel.

A "Call for Abstracts" has been issued and the deadline for receipt of abstracts is January 3, 1986. Abstracts must be submitted or sponsored by members of AMSAODD or RSA and there is a handling fee of \$30 per abstract. Abstracts must be submitted on special forms which may be obtained by writing to *AMSAODD-RSA Meeting, 12 West 21st Street, New York, NY 10010* or calling the Conference Manager at 203-227-7084.

The Program Committee is Co-Chaired by Floyd E. Bloom, M. D. (RSA) and Marc Galanter, M. D. (AMSAODD). The keynote address will be given by Dr. David Hamburg, President of the Carnegie Foundation and Past President of the American Association for the Advancement of Science.

The "Ruth Fox Course for Physicians" will again be offered, and the Course Director is Maxwell N. Weisman, M. D. Course date: April 18, 1986.

Registration materials and further details of the program will be available in January.

AMERICAN CANCER SOCIETY NEWS

Thursday, November 21, 1985 has been designated as the great American Smokeout, according to the American Cancer Society. Smokers are being asked to take a day off from smoking, and non-smokers are asked to "adopt a smoker" and help a friend to quit. Physicians are encouraged to ask their patients to "join the great American smokeout," on Thursday, November 21.

SPECIAL ISSUE OF JSCMA

The March, 1986 issue of *The Journal of the South Carolina Medical Association* will address the "cost-effective use of antimicrobial therapy," according to Editor Charles S. Bryan, M. D.

Contributions to fund this special issue have been received from Hoffmann-LaRoche, Inc., American Hoechst Corporation, Roerig Division of Pfizer Pharmaceuticals, Miles Pharmaceuticals, and SmithKline Beckman Company.

THE WAITING GAME: HOW DOES YOUR OFFICE RATE?

When space permits, the *Newsletter* editor will share with SCMA members information gathered at the first Annual AMA Communications Workshop, held in Chicago, October 31 - November 1, 1986. Following is the first installment.

The physician's image and good public relations begin in the doctor's office. Waiting time and scheduling problems have ranked as one of the greatest negatives of the doctor/patient relationship. The self-test below, devised by the Texas Medical Association, should help you isolate any waiting time problems in your office, design solutions to those problems that best suit your office style, and have a more positive relationship with your patients due to reduced waiting time.

1. *Do you know what time patients are scheduled to see you?* If you said yes, congratulations! You are conscious of when patients are scheduled and consequently will know when you are running late. If you said no, you run the risk of running behind and not knowing it. Unless a staff person informs patients of the delay, they won't know either!
2. *When you are delayed or notice you are running behind, do you inform your staff or patients?* If you said yes, you are dealing positively with the fact that sometimes you will run behind. If you said no, you may have a room full of waiting patients who are frustrated from not having an explanation.
3. *Does your staff let you know when a patient has had to wait a total of more than 30 minutes in the reception area and/or examination room?* If you answered yes, this shows you have great communications with persons in your office. If you answered no, you are missing an opportunity to build a stronger relationship with your patients.
4. *If you are called out on an emergency, does your receptionist inform patients of the delay and ask if they would care to reschedule?* Yes to this question shows you recognize that patients' time is valuable and tells them you care about how they feel. If your answer was no, patients may feel you don't think their time is valuable. If they don't know about the delay, the rest of their scheduled day may suffer and their frustration with you and your staff becomes greater.
5. *Generally, do you set aside time to return and make phone calls?* A yes answer means you are managing your time well and reducing the chance of falling behind. If you answered no, you may be building in schedule delays. Set aside a particular time of the day to return and make calls so you can keep to your patient schedule.
6. *Do you set aside a time for a break or free period?* A yes answer shows you are being realistic not only about the need for a break but about how useful a break can be to catch up when running late. If you said no, you may be experiencing more delays than are necessary. A break can help compensate for late appointments earlier in the day.
7. *Have you or your staff attended any practice management courses or seminars in the past three years?* If you said yes, then you have up-to-date information on running an efficient practice. If you said no, you may be experiencing more than your share of office problems -- particularly waiting time problems.
8. *Is your reception area a pleasant place to wait with comfortable furniture and varied reading material?* Yes means that even if your patients have to wait, they are in comfortable surroundings with interesting material to take their minds off waiting. No means mediocre surroundings and uninteresting reading materials may leave a negative impression on patients and make waiting seem even more of an inconvenience.

INFANT MORTALITY AND THE LOW BIRTHWEIGHT INFANT IN SOUTH CAROLINA: A TEN YEAR REVIEW, 1975-1985

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Infant mortality is defined as deaths per 1000/live births in the first year of life. More people in the United States die then than in any other single year of age up to 65.¹ Neonatal deaths (involving babies less than 28 days old) account for 66 percent of infant mortality; postneonatal for 34 percent. Seventy-nine percent of infants who die in the neonatal period are low birthweight ($\leq 5\frac{1}{2}$ lbs. or ≤ 2500 gms.).

The decline in infant mortality over the past ten years is most attributable to a reduction in neonatal mortality.² Little change has been noted in the postneonatal component of infant mortality. While the infant mortality rate has improved steadily over the last ten years, South Carolina now ranks as the state with the highest rate. It is significant to note that the declining rate in South Carolina and other states has been primarily through improved *survival* of infants in the low birthweight group and not through reduction in the *incidence* of low birthweight.

	1975	1984
Infant Mortality Rate (# deaths)	19.2 (897)	14.7 (743)
Neonatal Mortality Rate (# deaths)	13.7 (683)	9.7 (467)
Low Birthweight Rate (# LBW)	9% (4205)	8.7% (4232)

There has been little or no change for many decades in the distribution of birthweight despite multiple programs to improve the health of mothers and infants in South Carolina.³ The white low birthweight rate remains near six percent and the

black rate stays at 12 to 13 percent. Because black infants make up 40 percent of South Carolina's births, this accounts for our total low birthweight rate of 8.9 percent, the highest rate of any state in the nation. Our low birthweight rate problem lies not only with those infants born prematurely (less than 37 weeks completed gestation), but there is almost as great a problem with those infants who are small for their gestational age (SGA).

This paper describes the state programs that have been instituted over the past ten years which have contributed to improved infant mortality. These include: Regionalization of Perinatal Services, Perinatal Outreach Education Programs, and Statewide High Risk Program.

Also summarized are current projects aimed toward *prevention* of low birthweight infants. These include The Resource Mothers' Program, Nurse-Midwifery Adolescent Clinics, Preconceptional Intervention Program, Low Birthweight Prevention Program, Low Birthweight Prevention Workshops and Improved Access to Prenatal Care.

REGIONALIZATION OF PERINATAL CARE

The proposal to regionalize perinatal care, first initiated in 1975,^{4, 5} was intended to provide resources for the practicing physician and make available consultation services and medical facilities for any complexity in maternal and infant care in our state.

Since this program's onset, improvement in neonatal-birthweight-specific-mortality has been demonstrated in hospitals with neonatal intensive care units. Very low birthweight infants (≤ 1500 grams) have enhanced survival rates when cared for in neonatal intensive care units. This fact is probably the most important lesson learned in the regionalization of perinatal care in South Carolina.

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INFANT MORTALITY

Percentage S. C. Birth (1982) Very Low Birthweight (≤ 1500 grams)

	<i>Births</i>	<i>Survival</i>
Five Hospitals with NICU =	61%	75%
Hospitals without NICU =	39%	41%

PERINATAL OUTREACH EDUCATION

Perinatal outreach education has been demonstrated to be an essential component of regionalization and a definite adjunct to improved infant mortality.⁶

A self-paced modular program was used in 57 (86 percent) of the 66 hospitals with perinatal services in South Carolina. Seventeen hundred and thirty-six participants completed the Perinatal Continuing Education Program (PCEP).⁷

Evaluation of PCEP demonstrated the program to be a reinforcement of knowledge and skills of physicians and nurses as well as an instrument for acquiring new skills. Fifteen of the nineteen skills taught were related to the neonate and four to the fetus.

In order to meet the need for more information covering obstetrics, the Perinatal Education Program for Community Hospitals (PEPSC) was developed. This program consisted of ten intrapartum modules.⁸

An attempt was made to follow up on the "knowledge improves attitude improves practice" theory by studying perinatal outcomes in those hospitals using the program. There was an improvement in neonatal mortality, particularly for those infants less than 1500 gram (VLBW). Again, however, no improvement was seen in distribution of birthweight.⁹

As a community hospital based self-study program to improve knowledge of perinatal professionals, this program is being used in hospitals in 33 states other than South Carolina.

STATEWIDE HIGH RISK PROGRAM

The statewide high risk program serves women who are poor and who have medical risk factors such as hypertension, diabetes, or history of poor past perinatal outcomes. Pregnant women are screened in prenatal clinics and physicians' offices for eligibility.¹⁰

Studies of perinatal outcome of patients in the high risk program as compared to matched controls showed the program's significant effective-

ness in reducing the number of fetal and neonatal deaths, but again there was no significant change in distribution of birth weight.

Perinatal Mortality Rates by High Risk Program Participants

	<i>Program</i>	<i>Non-Program</i>
Fetal	15.2/1000°	23.3/1000°
Neonatal	15.5/1000°	27.5/1000°

° = $p < .05$ analysis of variance, program vs. non-program

Birthweight Distribution (%)

	<i>Program</i>	<i>Non-Program</i>
VLBW (≤ 1500 gms)	6.4%	5.4%
LBW (≤ 2500 gms)	17.9%	17.4%
ABW (≤ 2500 gms)	75.5%	77.1%

No difference between groups

Possible reasons for the program's effectiveness are the facts that a greater number of program women had more prenatal visits and were delivered in a Level II or Level III hospital by appropriate personnel.¹¹

The High Risk Program pays the physician's fee and hospital bill. A mother/infant package, which costs the program \$1500 at the onset in 1976, ten years later costs \$2700. With this inflationary factor in mind, more concentration and effort is being given to finding ways to reduce the number of low birthweight and very low birthweight infants with programs geared toward prevention.

RESOURCE MOTHERS

Babies born to teenaged mothers are at an increased risk for mortality, morbidity, and problems in development. In South Carolina, low birthweight and very low birthweight infants of mothers less than 18 years of age contribute heavily to our state's infant mortality. With adequate prenatal care, adolescents are reported to have no more complications of pregnancy and delivery than older mothers. However, the average number of prenatal visits for teenagers is well below the recommended care standards.

INFANT MORTALITY

The Resource Mother Program was developed with the primary goal of improving the perinatal care and outcomes of low income adolescents.¹² The role of the Resource Mother as teacher, role model, reinforcer, friend, and facilitator is to focus on the strengths of each young pregnant mother and encourage support from the mother's own network.

Preliminary data from a comparison of program and non-program patients of the same age and geographic location show no difference in the percentage of LBW infants. There was, however, a significantly lower number of VLBW infants in the program group.¹³

Resource Mothers Program				
	<i>Program</i> (<i>n</i> = 305)		<i>Non-Program</i> (<i>n</i> = 306)	
Low Birthweight	10%	(30)	13%	(41)
Very Low Birthweight	1%	(3)	4.5%	(14)

NURSE MIDWIFERY ADOLESCENT CLINICS

Using the Medical University Adolescent Clinic as a model, certified nurse-midwives have been utilized to give prenatal care to teenagers. In such a program, Piechnik and Corbett¹⁴ reported improved perinatal outcomes as regards birthweight. Unfortunately, this type of approach has not been generally accepted in the state due to lack of support for nurse-midwives by physicians.

Low Birthweight Rates (≤ 2500 grams) Adolescents (≤ 17 years of age)			
CNM Program (<i>n</i> = 738)		Controls (<i>n</i> = 2018)	
Total	= 9.1%	Total	= 12.7%
White	= 3.4%	White	= 7.2%
Non-White	= 10.2%	Non-White	= 14.5%

PRECONCEPTIONAL INTERVENTION PROGRAM (PIP)

Risks associated with low birthweight may be reduced before pregnancy. Early identification,

counseling with health education related to reproduction, and continued expansion of family planning services are other approaches being implemented.¹⁵

For some factors, risk reduction before conception may offer more protection than risk reduction during pregnancy. Early detection of complications such as diabetes, elevated blood pressure, or anemias leads to improved outcomes.

Prepregnancy consultation and risk reduction are especially important during the interval between pregnancies for women who have suffered a reproductive casualty. The association between a troubled obstetrical history and subsequent low birthweight delivery has been well documented.¹⁶

Risk consultations with the patient prior to pregnancy also provide an opportunity to explain the importance of prompt pregnancy diagnosis and early prenatal care.

LOW BIRTHWEIGHT PREVENTION PROGRAM

The literature is unclear at present as to whether specialized intensive prenatal care can improve birthweight. Few studies have examined prospectively the effects of altering maternal behavior in conjunction with prenatal care. This concept is being tested in a randomized clinical trial of low birthweight prevention in South Carolina.¹⁷

This multicentered randomized controlled trial utilizes nurses and nurse-midwives to provide intensive prenatal care and education to pregnant women identified as being at risk for low birthweight outcomes. Risk assessment is done through the use of an objective screening tool. Screening is done in the county health departments' prenatal clinics and through the WIC (Women, Infants, and Children) food supplementation program.

Eligible patients are randomized into program or control groups. Control group patients receive care as usual in one of the state perinatal high risk clinics. Program patients are followed in one of the five low birthweight prevention clinic sites (Charleston, Columbia, Greenville, Florence, and Spartanburg). A specially trained nurse or nurse midwife at each of these clinics follows the patient for prenatal care with frequent visits where emphasis is placed on reducing risks associated with low birthweight. The intervention focuses on (1) prevention or early recognition of preterm labor with weekly assessment of the cervix; (2) good

nutrition; (3) avoidance of adverse health practices such as smoking, alcohol and drug use; and (4) social support and stress reduction.

The results of this study should provide valuable information on the effect of this overall intervention on the incidence of low birthweight rates as well as the effectiveness of the screening tool for identifying women at risk for this problem.

LOW BIRTHWEIGHT PREVENTION WORKSHOPS

In early 1985, a grant awarded from the March of Dimes/National Foundation enabled the teaching of low birthweight prevention workshops. The purpose of these workshops was to provide an opportunity for nurses and physicians to increase their knowledge and awareness of factors related to low birthweight outcomes and to improve their skills in identifying patients at risk and providing intervention in clinical settings. A series of ten, three-day workshops was conducted at the Medical University for forty participants from health districts with Level II hospitals around the state. The workshop participants had the opportunity to observe the low birthweight clinic intervention as well as gain experience in early detection of subtle cervical change. Increasing awareness of the magnitude of the problem of low birthweight and its relationship to infant mortality and morbidity should improve risk assessment skills, and the quality of prenatal care in health districts around the state.

IMPROVED ACCESS TO PRENATAL CARE

Since South Carolina has the highest rate of low birthweight and very low birthweight infants in the United States, the South Carolina Department of Health and Environmental Control recognizes the importance of furthering knowledge in this area. Emphasis has been placed on assuring every pregnant woman access to prenatal care; monitoring maternal health to detect underlying disease; proper nutrition; and lifestyle changes, especially smoking, alcohol, and drug use.

As the well of financial resources begins to dry, the Neonatal Intensive Care Unit is an unlikely answer to further reduction of infant mortality. The future points toward prevention of poor fetal growth and prematurity, especially among those who do not have early access into a health system.¹⁸

SUMMARY

High quality perinatal medical care seems to improve survival in infants of low birthweight. However, the major determinant of infant mortality, low birthweight, is still as prevalent as ever in the state. Much effort is now being made in prevention of low birthweight, but no dramatic change has yet been seen. Improving the birthweight of South Carolina infants remains the unsolved challenge for the next decade! □

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SUDDEN INFANT DEATH SYNDROME — UPDATE

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Sudden death can occur at all ages, but when an infant less than one year old dies unexpectedly and for no apparent reason, it is called Sudden Infant Death Syndrome (SIDS). This article is a brief review of the current understanding of SIDS and near-SIDS. For readers who desire a complete review of the SIDS literature, several articles and books are listed as references.^{1, 2, 3, 7, 10, 13}

HISTORICAL PERSPECTIVE

Accidental suffocation was the Old Testament explanation for SIDS (I Kings 3:19-20). We now know that it is practically impossible to unintentionally suffocate a healthy infant by bedclothes or posture.¹ In the 19th and early 20th century, SIDS victims were thought to have suffocated because of a large thymus. This was called "status thymolymphaticus" and was occasionally treated with irradiation, which increased the risk for thyroid carcinoma.¹

Through the years, many hypotheses have been suggested as a cause for SIDS including immunizations, botulism, allergic reactions to cow's milk, hyperthyroidism, thiamine deficiency, hyperthermia, prolonged QT syndrome, abnormal metabolic/endocrine states, arrhythmias, anaphylactoid reactions, and infections. Many of these conditions may infrequently result in sudden death, but it is unlikely that any are associated with SIDS in the majority of cases.

Earlier this century, SIDS victims were thought to be completely normal, but recent evidence suggests that SIDS infants have subtle abnormalities prior to death.

DEFINITION

SIDS is the sudden, unexpected death of an apparently healthy infant in which autopsy examination fails to demonstrate a cause of death.³ Thus, by strict definition, a postmortem examination is required to exclude a known cause of death, which may be discovered in approximately 10 percent of unexpected infant deaths. The rate of

autopsy examination in suspected SIDS cases in South Carolina in 1982 was 70 percent, a significant increase from 40 percent in 1979.⁴

CASE HISTORY

The following case history describes an infant who died from SIDS and his sibling who has been evaluated and treated for increased risk of SIDS.

Twins were born at 31 weeks gestation by cesarean section because of premature labor, breech presentation and placenta previa. Twin A was male and had Apgar scores of nine and nine at one and five minutes, respectively. He weighed 1.5 kilograms and required oxygen the first day for transient tachypnea. He had no other complications during the hospital course and was discharged on day 31 weighing 2.04 kilograms. Eight days later the mother discovered him apneic at home. She stimulated him and brought him to the emergency room where he responded to cardiopulmonary resuscitation after 15 minutes. He died later that day and autopsy findings were consistent with SIDS.

Twin B weighed 1.26 kilograms at birth and had Apgar scores of eight and nine at one and five minutes, respectively. She also required oxygen the first day for transient tachypnea. Her hospital course was uncomplicated until on day 35 when she had an apneic spell in the nursery which required cardiopulmonary resuscitation. A polygraphic sleep pneumogram done prior to discharge revealed numerous short apneas, some of which were obstructive, and four percent periodic breathing. Several episodes of hypoxemia and bradycardia occurred during nipple feeding. After the parents were taught cardiopulmonary resuscitation, the baby was discharged on day 64 with a home monitor because of the twin sibling who died of SIDS, history of significant apnea and an abnormal polygraphic sleep pneumogram. The infant is now ten months old and doing well.

EPIDEMIOLOGY

Many studies have examined the epidemiology of SIDS and, in general, there is agreement on many of the findings. SIDS is the most common

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cause of death of babies one week to one year of age with an incidence of two deaths/1000 live births. Most deaths occur in the first six months of life with a peak age distribution at three to four months. Death usually occurs when the infants are presumed to be asleep. Thirty to forty percent of infants have evidence of a preceding mild respiratory tract infection. The risk for SIDS is increased in the poor and non-white population (five deaths/1000 live births).⁵ SIDS occurs more commonly in premature or small for gestational age infants and in infants with decreased growth after birth. The risk is increased in siblings of SIDS victims and in multiple births. The incidence of SIDS is similar in fraternal and identical twins, implying an environmental rather than genetic etiology. Males are more commonly affected and most deaths occur in the winter. Maternal factors that have been identified include unwed and younger mothers, mothers who smoke cigarettes, decreased prenatal care during pregnancy and short interpregnancy intervals. Data from South Carolina in 1982⁴ confirm many of these associations (Table 1). South Carolina had the highest infant mortality in the United States in 1982 and SIDS accounted for 33 percent of post-neonatal infant deaths,⁶ the largest single cause of post-neonatal infant mortality. The incidence of SIDS may be higher than that recorded on death certificates.

INFANTS AT INCREASED RISK FOR SIDS

Most infants who will die from SIDS cannot be identified prior to death. However, there are babies at increased risk for SIDS who can benefit from early intervention (Table 2).

Siblings of SIDS victims have a one to two percent risk for SIDS. Babies of mothers addicted to narcotics have a five to tenfold increase in the incidence of SIDS compared with infants not so exposed.⁷ Eleven percent of babies with bronchopulmonary dysplasia have been reported to die from SIDS.⁸

AUTOPSY EXAMINATION

The most important finding of SIDS victims at postmortem examination is that there is no inherently lethal pathology discovered. There may be evidence of a mild viral respiratory infection. Intrathoracic petechiae are commonly seen and are suggestive of prior hypoxia associated with increased respiratory efforts or viral infection.¹

Table 1
EPIDEMIOLOGY OF SIDS
IN SOUTH CAROLINA — 1982

1. 107 reported cases (2.16 deaths/1000 live births)
2. Race: 44% white, 56% non-white
3. Sex: 64% male, 36% female
4. Birthweight <2500 grams: 27%
5. Multiple births: 5.6%
6. Age at death: 1-3 months — 65%
7. Maternal characteristics:
 - 1) <20 years old — 31%
 - 2) Unmarried — 46%
 - 3) Lack of prenatal care — 24%

Table 2
INFANTS AT INCREASED RISK FOR SIDS

1. History of severe apneic episode
2. Pneumocardiogram documentation of prolonged apnea or increased periodic breathing
3. Sibling or twin of SIDS victim
4. Severe feeding difficulties with apnea and bradycardia
5. History of severe bronchopulmonary dysplasia
6. Infants of mothers addicted to narcotics

Abnormalities suggesting chronic or recurrent hypoxia are present in approximately 50 percent of cases and may include hypertrophy of the pulmonary arteriolar muscle, right ventricular hypertrophy, retention of periadrenal brown fat, extramedullary hematopoiesis and proliferation of astroglial cells in the central nervous system. The different findings reported by pathologists can partially be explained in that SIDS may be caused by more than one etiology.

ETIOLOGY

It should be kept in mind that SIDS is probably caused by a number of different processes. Because an anatomic cause of death cannot explain the death of SIDS infants, the cause of death must be a disorder of physiologic function. Two final pathways are possible to explain the mechanism of death: respiratory or cardiac arrest. Overwhelming evidence suggests that apnea is the mechanism of death in most SIDS infants,¹ although SIDS may infrequently result from an arrhythmia.

Apnea can be caused by sepsis, meningitis, pneumonia, hypoglycemia, hypoxemia, hypocalcemia, central nervous system abnormalities, vagal stimulation, obstructed airway or laryngospasm induced by seizures or gastroesophageal reflux. If the etiology for the apnea is not appar-

ent, it is called apnea of infancy (apnea greater than 20 seconds or shorter apneas associated with bradycardia, cyanosis or pallor).³

It should be emphasized that all babies have short respiratory pauses (less than 10 seconds) during sleep. Gunteroth¹ has observed that "sleep apnea is a universal phenomenon which is usually of brief duration and harmless. . . . Failure to arouse is the crucial element in SIDS." Thus, regardless of the cause of apnea, babies who succumb to SIDS do not commence breathing during apnea, probably secondary to abnormal arousal responses. In the first month of life, babies respond to severe hypoxemia by gasping until regular respirations resume. The effectiveness of the gasp mechanism is the probable explanation for the low incidence of SIDS in neonates.¹

There is a temporal relationship between immunizations and SIDS, as immunizations are routinely given at two and four months of age, when SIDS is most prevalent. However, there is little evidence to suggest a causative relationship between SIDS and immunizations.⁹

CONTROL OF VENTILATION IN AT-RISK INFANTS

Several investigators have identified abnormal breathing patterns or respiratory control mechanisms in infants in whom SIDS later occurred. Episodes of prolonged apnea, increased periodic breathing and excessive short apnea, sometimes with obstruction, have been detected with sleep pneumograms in infants who later died from SIDS.¹⁰ Abnormal ventilatory and arousal responses to mild hypoxia or hypercarbia have also been reported.^{10, 11} These observations point to a defect in control of ventilation in some SIDS infants.

EVALUATION OF THE HIGH-RISK INFANT

Infants at increased risk for SIDS can be reliably evaluated and monitored. Infants who present with apnea should be hospitalized and a thorough history obtained, particularly describing the events prior to, during and after the apnea episode. In general, sleep apnea is more serious than apnea while the infant is awake.

The differential diagnosis for infants who present with apnea includes sepsis or meningitis, child abuse, seizure disorder, gastroesophageal reflux, metabolic disorders (hypoglycemia, hypocalcemia, hyponatremia), central nervous system

disorders and heart disease or arrhythmias. After a careful physical and neurologic examination, laboratory tests should be obtained to identify known causes of apnea. Routine tests include chest x-ray, urinalysis, complete blood count, calcium, glucose, electrolytes, electroencephalogram and electrocardiogram. Optional tests, depending upon the clinical presentation, may include upper gastrointestinal radiographs, CT scan, metabolic studies, and spinal fluid examination.

The best way to determine if an infant has respiratory abnormalities during sleep is to perform a sleep study. A two-channel sleep pneumogram can provide information regarding central apnea, periodic breathing and bradycardia during sleep. The polygraphic sleep pneumogram can additionally distinguish central and obstructive apnea, arrhythmias, abnormal oxygen or carbon dioxide levels, sleep state and apneas associated with seizures or gastroesophageal reflux. Ventilatory response testing can detect infants with abnormal chemoreceptor arousal reflexes, which are critical for the termination of an apnea episode.

The polygraphic sleep pneumogram together with chemoreceptor arousal reflex responses provide important clues to the baby's control of ventilation. However, these tests may have false positive or false negative results, and therapy must be considered in the context of the infant's clinical presentation.

THERAPY

Any predisposing condition which may cause apnea should be treated. Infants with obstructive sleep apnea secondary to enlarged tonsils or adenoids may benefit from surgery.¹²

Infants at increased risk for SIDS (Table 2) should be prescribed with a home cardiorespiratory monitor. It has been reported that two-thirds of infants who present with apnea of infancy will have recurrent apneas associated with pallor or cyanosis.¹⁰ The risk for sudden death is two to six percent even with the use of home monitors.³

Home monitors have been significantly improved over the past several years but there continues to be a problem distinguishing true from false alarms. Another problem is the adjustment the parents must make because of the constant need to be available to respond to alarms whenever the infant is asleep.

SUDDEN INFANT DEATH

Obviously, the home monitor can only detect central apnea or bradycardia, and if the monitor alarms the parents must be prepared to provide stimulation or cardiopulmonary resuscitation. This usually requires several intensive cardiopulmonary resuscitation training sessions for parents and caretakers of the baby.

Close follow-up and psychosocial support of the family is of critical importance if the home monitor is to be used successfully. A monitoring family support group can help these families cope emotionally during the time their infant is on a monitor. Alternate caretakers can be trained in the use of home monitors and resuscitation, thereby alleviating the parents' constant responsibility.

Although there is controversy regarding the use of home monitors, a near-SIDS infant, or previous child with SIDS, is all that it takes for parents to feel anxious about their child. Providing home monitors does something to prevent SIDS and reduces parental anxiety.

The criteria for discontinuing the home monitor varies among physicians. At a minimum, the baby should be six months old (corrected for gestational age, if premature), two months since having a significant apneic episode, and experienced an upper respiratory tract infection or immunization without occurrence of apnea.¹³ A normal sleep pneumogram can be reassuring prior to discontinuation of the home monitor.

Theophylline therapy may be rarely indicated for selected infants with excessive central apnea or periodic breathing.¹³ However, theophylline may be associated with hyperactivity, sleep disorders, tachycardia, vomiting and exacerbation of seizures or gastroesophageal reflux. Therapeutic levels should be obtained, and the dose decreased if side effects are encountered.

CONCLUSION

We still need to gain more knowledge regard-

ing the incidence and pathophysiology of SIDS. Epidemiologic information can be acquired by listing SIDS on death certificates and obtaining autopsies on suspected cases. At-risk infants should be thoroughly evaluated and treated, and careful follow-up and psychosocial support for these families maintained. Further investigations examining the physiologic differences in near-SIDS infants will hopefully improve our ability to detect at-risk infants, and thereby reduce the incidence of SIDS in the future. □

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FINANCIAL CHECKUP

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WHAT YOU SHOULD KNOW BEFORE YOU BUY STOCK.

How to read a Financial Statement.

The previous months newsletter focused on "Getting the True Picture" of a company prior to investing in that particular company...To help you further make up your mind, you should also look at a company's financial statement/annual report....An annual report is generally published a few months after the end of the company's fiscal year and can provide a wealth of valuable information for you when analyzing the firm. In addition to an introductory letter from management and a detailed explanation of the company's line(s) of business, it's the place where you can find all the details of a company's financial status. That's because the annual report contains three important financial statements: the Balance Sheet, the Income Statement and the Source and Application of Funds Statement, all located in the financial section of the report. The figures provided in these statements should help you analyze a company's performance from year to year. They also give a benchmark for comparing different companies in the same industry. Although there are many figures to look at and a variety of ways to compare different items, I'll explore some helpful techniques for analyzing your company.

The Balance Sheet is divided into three general categories: Assets - what the company owns; Liabilities - what the company owes; and Stockholders' Equity - the difference between assets and liabilities; the amount received by the company through sale of stock, plus retained earnings.

This statement gives you the company's financial condition on a given date, usually the end of the year or fiscal year. In addition, most balance sheets provide you with the previous years' financial data to help you get a clearer picture of the company's year-to-year progress.

The categories of assets and liabilities are broken down into two types: current and long-term (or fixed). Current assets or those expected to be converted into cash within 12 months, and current liabilities, those liabilities expected to be paid within 12 months, can be the most helpful as a means of analyzing your company's financial health. By comparing current assets to current liabilities (simply divide c.a. by c.l.), you can arrive at a company's current ratio. Minimum safety for many industries exists when current assets are at least twice as large as current liabilities (i.e., the current ratio equals two or more).

Current assets less inventories gives you a company's quick assets, those current assets which are most quickly convertible into cash. And, to take the formula one step further, quick assets less current liabilities gives you net quick assets. In most industries, a company in solid financial shape will have quick assets which exceed liabilities by a reasonable amount, thereby showing its ability to meet its financial obligations.

Other kinds of comparisons - comparing sales to inventory to come up with

Financial Check-up (Cont'd)

inventory turnover, or looking at inventory as a percentage of current assets - are also helpful analytical techniques. However, you should realize that the norm, in terms of these figures, will vary depending on the type of company you're looking at and even on the time of year.

Proceeding down the stockholders' equity section of the Balance Sheet, you'll want to look at your company's capitalization ratios. These are the proportions of each type of security by which the company is capitalized (i.e., preferred stock, common stock, bonds, etc.). Capitalization ratios are easily computed by dividing the securities by which the company is financed. This can help you determine how attractive your company is. For example, you may not look too favorably on a company with a disproportionately large amount of bonds or preferred stock compared to common stock. That's because bond interest and preferred dividends must be paid before a common stock investor (which could be you!) is entitled to dividends.

The Income Statement, also called the Profit and Loss Statement, provides the company's performance figures over a full year's time and can, therefore, give investors a good indication of how well the company will perform in the future. Like balance sheets, almost all income statements show operating activities over two years.

The Income Statement's primary function is to show investors: *How much was received from selling goods. *How many expenses were involved in order to operate the company, and *the difference between sales dollars and expenses which is, of course, a company's net profit. (If expenses exceed sales, the Income Statement will show a net loss.)

Again, as with analyzing the Balance Sheet, some comparisons may prove helpful here. By dividing the company's net profit by its sales you come up with its net profit ratio. This shows you how much profit (after taxes) the company earned for each dollar of sales. A ratio of 20% means that for each sales dollar, there remained 20¢ as net profit from business operations. This figure should be compared to previous years' net profit ratios as well as the ratios of other companies in the same or similar industry.

Net earnings per share - how much money the company earned per share of stock issued - is another significant figure you'll want to pay special attention to on the Income Statement.

The Source of Application and Funds Statement can give you a good idea of how the company financed its growth during the year ("the source" of its money) and its "application" of funds - where the money went. This statement essentially bridges the other two.

Net earnings and cash dividends paid are two of the most important items to focus on when studying the Source of Application and Funds Statement for reasons outlined in the accompanying article. Briefly, these figures allow you to focus on a company's dividend policy (especially important for income-oriented investors) and future growth potential. The next issue will discuss the next steps necessary you should take prior to investing.

FURTHER INFORMATION

If you would like to receive further information on any of the topics covered in this newsletter, please write to Martin Lefkowitz, CFP, E.F. Hutton & Company, Inc. 2700 Middleburg Drive, Suite 200, Columbia, SC 29204; or Call (800) 922-1112.

* * * * *

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Leonard Douglas is gone. It is almost impossible to realize that never again will I see his warm smile or feel his firm handshake or the friendly pat on the shoulder. Never again will we remember together old times, discuss present problems and pleasures, or plan for the future together.

It is impossible to do justice to Leonard with a few words any more than an old sailor could tell you of his love for the beauty and majesty of the ocean by means of a few shells in his hands. I won't dwell on Leonard's offices and honours, because most of you know all about them. I will say that Mary Anne and Leonard have been close friends for more years than I care to count. They were bright, cheerful, and fun to be with. They both had a good sense of humor. They were comfortable people who would be equally at ease in a hovel or a palace.

One of my favorite pictures as a child was Sir Luke Fildes' "The Physician." Many of you probably are familiar with the portrait of the dedicated physician of the last century sitting devotedly by the side of a sick child while anxious parents look on. Like most physicians of the last century, he was short on effective medicines but long on compassion and devotion to duty. I have always felt that Leonard combined the compassion and devotion of Sir Luke Fildes' physician with the knowledge and skill of modern day practice. Beyond that he had a burning desire to make sure that the private practice of medicine continued for the benefit of the patient through his work in organized medicine. Above all, Leonard Douglas had an abiding love for his family, for his patients, for his church, for his community, and for the welfare of his fellow physicians.

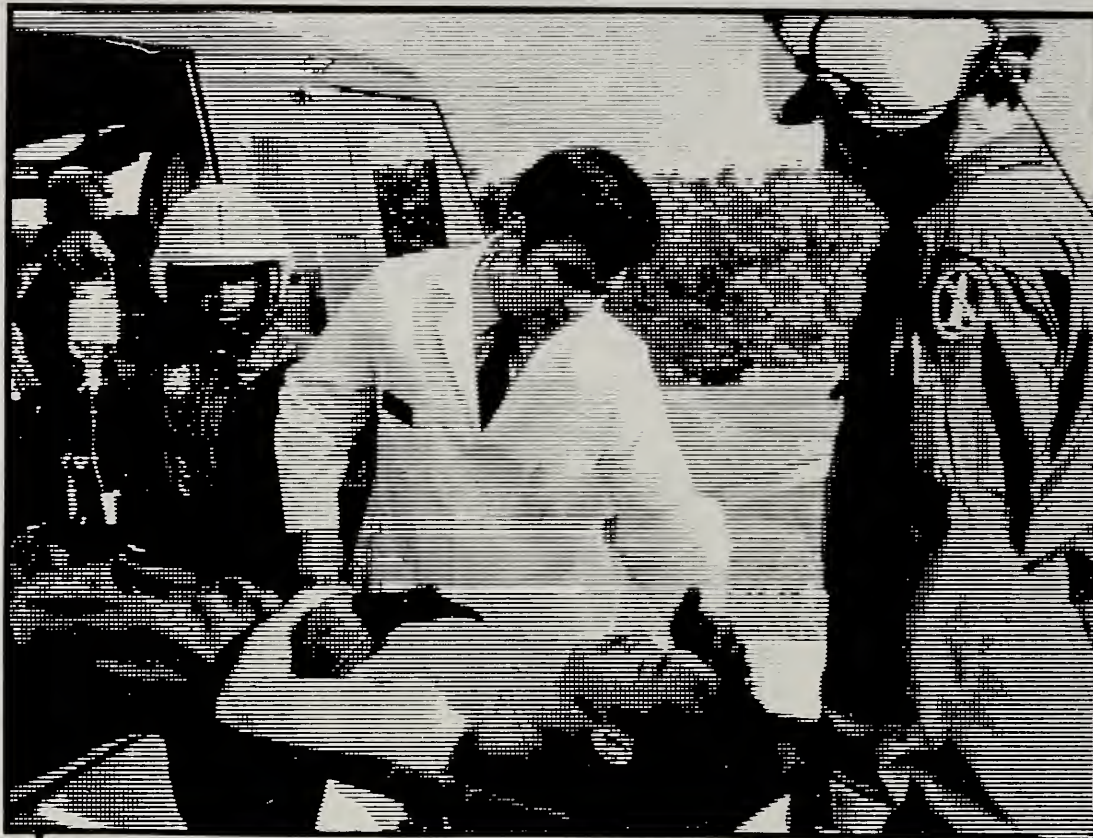
And yet on that warm bright Friday afternoon when all of us gathered together to pay our respects in Leonard's memory, I realized that he had not left us. The church in the design of which he played a leading part as an elder reflected the warmth and friendliness of Leonard Douglas with its pleasant and harmonious combination of stained wood, brick and glass. On this day the church which was designed to hold about 300 people was filled with almost double that number including 74 pallbearers and honorary pallbearers — many of whom were physicians from all parts of the state. They filled the sanctuary, the aisles beside the chancel, the narthex and the large church lounge behind the narthex. Everyone there knew that from now on their lives would be different.

Yes, Leonard, as a physical person, is no longer with us. There is no colossal building, no bronze statue, and no memorial plaque to commemorate his name. But more important, the spirit of Leonard is alive in the hearts of the multitude of people who knew him, respected him, and loved him — his family, his friends, his fellow physicians and his patients. The spirit of Leonard is alive in his and Mary Anne's two sons, Len, a practicing physician in Greenville, and Robbie, an insurance executive in Columbia. Somehow it is comforting for me to know that there is still a Dr. Leonard Douglas. We will always remember Leonard in the words of Isaiah:

“For the Lord has comforted His people
And will have compassion on His afflicted.
But Zion said, ‘The Lord has forsaken me,
My Lord has forgotten me.’
Can a woman forget her sucking child,
That she should have no compassion on the son of her womb?
Even these may forget,
Yet I will not forget you
Behold, I have graven you on the palms of my hands!”

DONALD G. KILGORE, JR., M.D.
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ON THE COVER: SOUTH CAROLINA MEDICAL RECONSTRUCTION

Following the conflagration that consumed much of the South during the Confederate War, the status of medical education was at a low point in South Carolina. The city of Columbia was described as a "wilderness of ruins with its heart a mass of blackened chimneys and crumbling walls." Charleston was a "city of ruins, of desolation, of vacant houses, of widowed women, of rotting wharves, of deserted warehouses, of weed-wild gardens, of miles of grass-grown streets, of acres of pitiful and voiceful barrenness." The tale of these two cities as they approached the problem of restoring an academic medical community continued far beyond the limiting years of the War Between the States.

Standing are Dr. _____, Drs. F. L. Parker, George E. Trescot, Dr. _____, Drs. Manning Simons, and F. Peyre Porcher. Seated are Dr. _____, Drs. J. Ford Prioleau, F. M. Robertson, and R. A. Kinloch. Other members of the faculty in 1873 were Drs. Middleton Michel, C. U. Shepard, J. F. M. Geddings, and J. P. Chazal. Perhaps the readers will help us fill in the blanks.

When the war ended, the medical community did the best it could to establish its former institutions. In 1865, the Medical College at Charleston began to reconstruct its former position, both financially and physically. In early 1865, Doctors Eli Geddings, James Moultrie, J. J. Chisolm and William Hume met in Charleston to reorganize the faculty of medicine. This was complicated because of the lack of all records, including the registration materials and minute books which had been lost during the war. The Medical College buildings had been shelled. The museum had been plundered and all of the furniture and equipment had been stolen. Nevertheless, a small poly clinic was organized under the leadership of Dr. Eli Geddings at Roper Hospital. This consisted of a free outpatient department staffed by faculty and students. The early faculty, among its other privileges for being allowed to teach medical students, was assessed \$100 each in order to pay for their teaching positions. The city of Charleston, under the directions of her Mayor, agreed to turn over the City Hospital to the college in 1868, and this facility was to continue in use by the teaching establishment in that city for many years. Times

were extremely difficult and few students had the training background or financial ability to attend the medical school, even though the total cost of enrollment for matriculation was \$65. The educational efforts continued, however, and in 1878 the charter of the college was renewed. This allowed the more secure position of the teaching institution and placed the facility on a more secure financial basis. The earthquake of 1886 brought additional hardship to the struggling medical faculty, as it did great damage to the buildings, rendering many unfit for habitation. In January of 1887, the state legislature appropriated \$5,000 for the restoration of the school. With time and effort the facility prospered, and forward-thinking leadership brought to consideration the extension from a three-year course to a four-year course of study inaugurated in 1899. In 1894, the faculty resolved to admit female students to the college. In that same year, the first considerations for a School of Dentistry were discussed, as well as the creation of a Department of Mental Diseases.

The tale of two cities does not end with the dissolution brought about by the Confederate War, as a conflict developed between the cities of Charleston and Columbia regarding where the medical school should continue to function. As reported by J. I. Waring in his *A History of Medicine in South Carolina*, a proposal was presented to the state legislature that a medical school be established at the University of South Carolina. This early medical school in Columbia was under the direction of Doctors A. N. Talley and J. T. Darby. The Medical College at Charleston sent a memorial to the legislature in 1886 showing the inexpediency of having a second medical school in the state. However, the University of South Carolina was successful in countering this memorial. The Medical School at the University lasted for only eight years. It is reported that the whole University was in bad shape and that only 45 students were enrolled in 1866. The plans for broadening the medical curriculum were advanced by offering free attendance to the school. In 1873, Henry E. Hayne, who was the black reconstruction Secretary of State, registered as a student in the Medical School. At this time Doctors Tally, Gibbes, and LaBorde, who were the

remaining faculty in the school, resigned. As one newspaper reported, "Hayne had no real desire to study medicine and entered the Medical School only to test the professors." The school never recovered from these resignations and ceased entirely to function in 1876.

These early efforts to restore medical education in South Carolina were plagued by difficulties and facilities, finances and the availability of students with preliminary qualifications to enter the medical institutions. Then, as is now, there were significant problems regarding the political arena which influenced the financing of these medical institutions. But no one would argue that as the years have passed the medical community of South Carolina has indeed been reconstructed and the tale of two cities has a bright outlook, as medical education of the highest caliber is now available in both those cities in their fine medical institutions.

— THOMAS M. LELAND, M.D., Ph.D.

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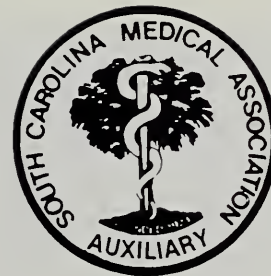
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SOUTH CAROLINA MEDICAL ASSOCIATION AUXILIARY



CONFLUENCE: FOCUS ON LEADERSHIP TRAINING AND HEALTH ISSUES

At the Leadership Confluence of the American Medical Association Auxiliary, more than 250 county Presidents-elect received leadership training and attended break-out sessions on current health issues. South Carolina participants included Brenda Cate, Lexington; Pancye Hunt, Colleton; Carolyn Jones, Florence; Ann McQueen, York; Kathy Whitten, Oconee; and Sheila Yates, Horry.

The Leadership Confluence was held October 6-8, 1985, at the Drake Hotel in Chicago, Illinois. Designed to train future officers for the state and county auxiliaries, the Confluence was also attended by state President, Skippy Adkins; President-elect, Susanne Black and Staff Director, Donna Murphy; national board and committee members, Billie Brady and Sheila Davis; and Past Presidents and honorary members.

Held annually, this meeting featured break-out sessions conducted by nationwide speakers who are experts in their respective fields. A variety of sessions were offered to help participants strengthen their leadership skills in such areas as budgeting, managing the Presidency, grass roots fund-raising, working with the media, parliamentary procedure, effective involvement in legislation, participation in the American Medical Political Action Committee, and making a smooth transition from one administration to another.

A membership workshop was conducted by Carol Benjamin, Director of Marketing and Communication at the National Association of Business and Education Radio.

M. Roy Schwarz, M.D., Assistant Executive Vice President for Medical Science and Education at the American Medical Association, gave a presentation on the "Rising Costs of Medical Care."

A session on "Community Services for Older Americans" focused on the combined health and social needs of the aging and some of the programs that can be implemented to meet those needs. This topic is an additional focus of the AMA Auxiliary's Shape Up for Life campaign, which is a nationwide program promoting good health.

Two sessions were offered as part of the AMA Auxiliary's commitment to act as a support system for the medical family. A session on "Coping with Malpractice" explored the impact this litigation has on the physician and family. Methods were presented for dealing with the stress caused by malpractice suits, including specific procedures for starting self-help groups. A presentation on "Impairment — The Physician and Family" discussed how the impairment of an individual affects the entire family and what can be done about it.

James H. Sammons, M.D., Executive Vice President of the American Medical Association, delivered the keynote address at the opening dinner on Sunday, October 6. At a breakfast on Monday, October 7, Francis G. Edwards, Senior Vice President of Louis A. Allen Associates, Inc., (Palo Alto, CA), explained "Leadership Strategies." At the final luncheon, AMA President Harrison L. Rogers, Jr., M.D., discussed changes in the health care system in a positive and optimistic speech. Auxiliary members left Confluence filled with enthusiasm and anxious to translate into action all they had learned.

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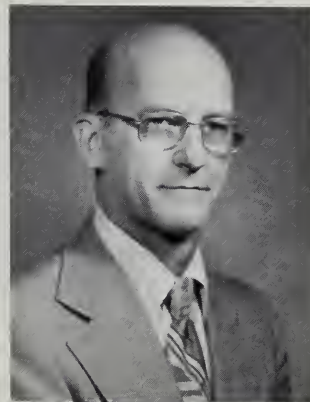
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BET YOUR MONEY AND SLEEP IN THE STREET

Dear John:

It certainly was great to see you at the special House of Delegates' meeting in Columbia. I was very impressed with your comments and am delighted that you will work to support the efforts of the Association. Tort Reform is an absolute necessity and we must get something done before the great explosion occurs. As I said there, we need fairness restored in the system and it can be done without hurting anyone.

Remember Dr. O'Driscoll who taught us anatomy? He had all sorts of sayings and I remember one in particular: "Sometimes you just have to bet your money and sleep in the street." Well that day has come on this issue and it will take a unified effort by all of us to improve the situation.

I'm sorry your partner did not get to the meeting but you must tell him that he is just as much a part of this effort as you and I. Much remains to be done. I want you to start on your Legislator who you have treated for many years and get him to understand the predicament as it exists today. Individual effort back home before the Legislature starts and at the beginning of the Legislature will have a large impact on the outcome.

You also wanted to know about those pictures. I'll give you a hint. Do you remember the Hormel All Girls Marching Band composed of all ex-WACS and WAVES that visited Charleston one week during our Junior year?

Yours truly,

A handwritten signature in dark ink, appearing to read "J. Gavin Appleby". The signature is fluid and cursive, with the last name being particularly prominent.

J. GAVIN APPLEBY, M. D., *President*



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We request that manuscripts be concise (no longer than 8 typewritten pages, double-spaced), with no more than ten references. These should be cited in the text in superscript, e.g., "Bottsford, et al.³", and should conform to the following style: "3. Bottsford JE, Bearden RC, Bottsford JG: A ten year community hospital experience with abdominal aorta aneurysms. *J S C Med Assoc* 79: 57-62, 1983." Ordinarily, publication of four small illustrations or tables or the equivalent will be paid for by *The Journal*. Manuscripts should be submitted in duplicate. Reprints will be made available by the publisher.



CHILD ABUSE: THE ROLE OF RADIOLOGY

R. I. MACPHERSON, M.D.*

In 1946, John Caffey¹ observed in six infants an association between subdural hematoma and multiple long bone fractures in various stages of repair. These fractures appeared in otherwise normal bones and the cause was either unknown to or concealed by the child's custodians. He concluded that these lesions were the result of multiple episodes of willful trauma. Thus, Caffey, a pediatric radiologist, is credited with the first description of what was later to be called "the battered baby syndrome." Since then, his findings have been confirmed by several other workers. The most notable radiologic reviews on the subject are authored by Silverman,² Gwinn,³ and Caffey⁴ himself. They emphasize the important role of the radiologist, not only in confirming the diagnosis in suspected cases of child abuse, but in recognizing the characteristic signs in unsuspected cases. They also stress the social and legal responsibilities that accompany this diagnosis. In this paper, the contribution of the radiologist in the recognition and management of abused children will be updated and reviewed.

First, let us consider the radiologist's role in the diagnosis of child abuse in cases where the diagnosis is suspected on the basis of the history and physical findings. In these instances, the referring physician is seeking conclusive proof of skeletal or internal injury to substantiate the diagnosis and direct the medical, social, and legal management of this patient. A radiographic survey of the skeleton should be performed and include the upper and lower extremities, skull, rib cage, and small

bones of the hands and feet. A technitium 99m methylene diphosphonate bone scan may complement the skeletal survey with its ability to detect healing fractures imperceptible on the radiographic studies.⁵ However, because of the normal increased activity at the growth plates, the commonly occurring metaphyseal fractures may be difficult to differentiate on the bone scan.⁶ Furthermore, bone scintigraphy cannot evaluate the age of fractures as can the skeletal survey. For these reasons, the bone scan, by itself, is not recommended as a screening procedure for skeletal trauma in child abuse.

Skeletal injuries remain the most common and most characteristic radiologically demonstrable findings in cases of child abuse. The most frequent sites of fracture are the long cylindrical bones, skull and ribs, in that order.⁶ The spine, pelvis, hands and feet are less prevalent sites of injury. Several patterns of injury may be encountered. The first, and least specific, is a single fracture. It is difficult to develop the diagnosis of child abuse on the basis of a solitary fracture unless the type of fracture is incompatible with the nature of the alleged injury. For example, a spiral fracture implies a twisting injury and will be incompatible with a history of direct blow or crushing injury. A fracture of a large cylindrical bone, such as a femur, in an infant, is always hard to justify and should prompt a search for other injuries. The second pattern, that of multiple fractures all in the same stage of healing, also is hard to pin down as child abuse particularly if a plausible history of accidental trauma is elicited. Occult fractures, that is those occurring without a known history of trauma, on the other hand, should arouse suspi-

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cision of child abuse. The extremities are the most common site of fracture in battered babies, but less than half are occult. Over 80 percent of rib fractures, however, are unsuspected.⁶ On this basis, multiple occult rib fractures should excite a high index of suspicion of child abuse. The third, and most characteristic pattern of skeletal injury, is multiple fractures in varying stages of healing. The majority of the traumatic lesions will be obvious fractures differing from those of known accidental trauma only by their multiplicity and varying age. There are, however, certain types of bony injury that are not associated with ordinary trauma. Metaphyseal fragmentation (Figure 1), for example, is the most characteristic single radiologic sign of child abuse. Recent radiologic-pathologic correlative studies have shown that these small metaphyseal fragments are part of complete fractures through the metaphysis rather than "bucket handle" injuries as previously described.⁷ They can be found at the metaphyses of almost all tubular bones, but are most common around the knee and ankle. They result from traction rather than impact injuries being secondary to the shearing, twisting and stretching forces that accompany pulling or shaking an infant.² Exuberant subperiosteal new bone formation (Figure 2) is another characteristic sign of child abuse. It is the result of repeated subperiosteal hemorrhages associated with repetitive trauma. Band-like, irregularity of the metaphyses (Figure 2) is also suggestive of child abuse. This reflects

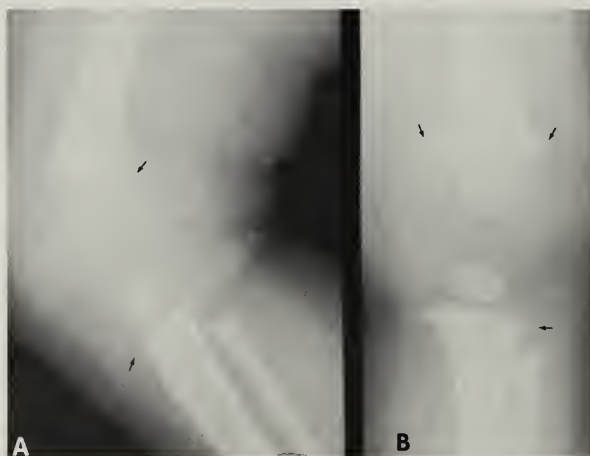


FIGURE 1: This 7-month female had a swollen knee following an alleged single episode of minor trauma. Radiographs of right knee (A) lateral and (B) anteroposterior showed multiple metaphyseal fragmentations (arrows). Subsequently, a skeletal survey revealed similar findings in the other extremities as well as an occult skull fracture. A diagnosis of child abuse was made.

repeated re-injury of metaphyseal fractures and is not seen in ordinary, adequately treated fractures. The infant with multiple fractures in varying stages of healing may demonstrate one or all of these characteristic injuries in addition to non-specific fractures.

Although the patterns of skeletal injury described above are virtually pathognomonic of child abuse, there are some disease processes that have radiologic features similar to those of battered infants.⁸ For example, growth plate injuries in infants can be secondary to birth trauma, metabolic bone diseases, neurogenic sensory deficit, Menkes syndrome and other generalized diseases. In addition, excessive subperiosteal new bone formation may accompany infantile cortical hyperostosis, congenital syphilis and vitamin A intoxication. Possibilities, such as these, should be excluded by clinical history, laboratory findings and additional radiologic features.

Skull fractures are a common feature of the "battered baby syndrome" and they also may be multiple (Figure 3). Whether or not a cranial injury is demonstrable, the possibility of an intracranial lesion such as subdural, epidural, or intracerebral hemorrhages must be considered. This is the most common cause of death and disability in cases of child abuse.⁸ For this reason, computed tomography (Figure 4), or where available, magnetic resonance imaging of the cranium is mandatory. Spinal fractures are an infrequent finding in child abuse. Nevertheless, whiplash shaking of

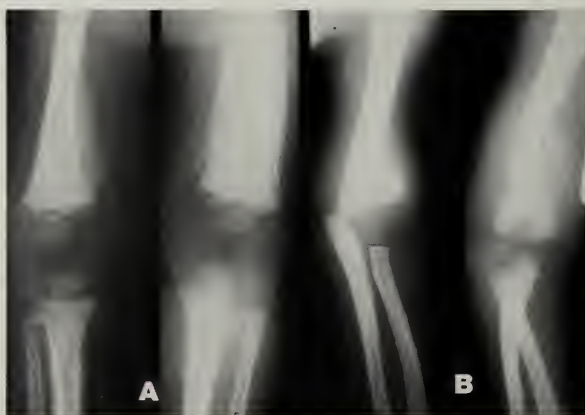


FIGURE 2: This 10-month male was admitted with multiple bruises. Radiographs of the lower extremities (A), right (R), and left (L); and the upper extremities (B), right (R) and left (L) showed multiple fractures of varying age. Exuberant subperiosteal new bone formation is seen on both distal femora and band-like metaphyseal irregularity in distal femoral and proximal left tibial metaphyses. A diagnosis of child abuse was established.

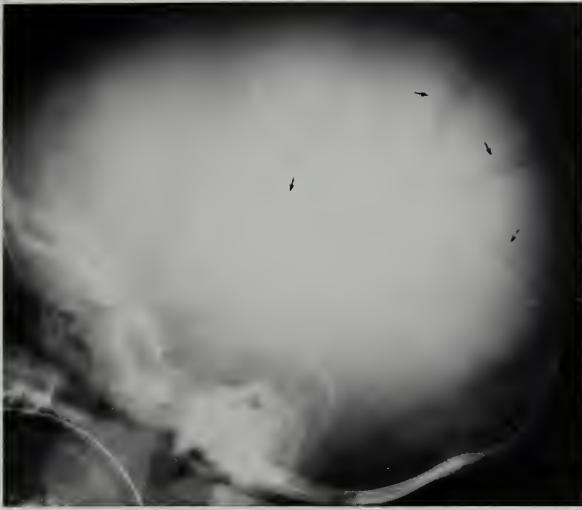


FIGURE 3: This 3-month female presented in the Emergency Room with cardiorespiratory arrest, and subsequently died. Chest radiography showed multiple rib fractures of varying age and this skull film revealed multiple fractures (arrows). These findings were key evidence in the litigation that followed.

an infant can cause fracture dislocations of the spine, anterior notching or compression of the vertebral bodies with a potential of serious spinal cord injuries.⁹

The possibility of other extraskeletal manifestations of child abuse should always be kept in mind.² Lung contusion or laceration, hemothorax or pneumothorax have been known to accompany thoracic trauma and will be perceptible on plain chest films. Abdominal ultrasound, computed tomography, or magnetic resonance imaging may be employed to demonstrate intra-abdominal lesions such as pseudocyst of the pancreas (Figure 5), liver, spleen, or kidney injuries. Upper gastrointestinal studies remain the best way to demonstrate small bowel hematomas and cystography the best method of excluding bladder rupture (Figure 6).

Frequently all these examinations will fail to demonstrate any radiologic evidence of skeletal or extraskeletal injury. This circumstance is both good and bad. It is good that a child does not have a demonstrable injury, but bad if lack of radiologic proof of injury prohibits removal of an abused child from an undesirable environment.

Now, let us consider the role of the radiologist in the recognition of child abuse in cases where the diagnosis is unsuspected by the referring physicians. The provisional diagnosis in this type of case is quite variable. A blood dyscrasia may be suspected on the basis of cutaneous bruising or os-

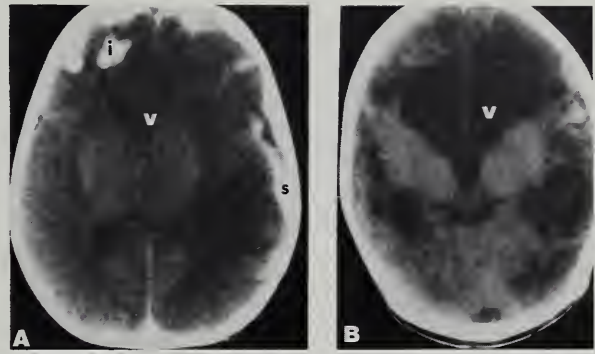


FIGURE 4: This 3-month male was badly battered. Cranial computed tomography on admission (A) showed intracerebral (i) and subdural (S) hemorrhages with displacement of the normal sized lateral ventricles (V) to the right. A repeat study, one month later (B), showed multiple low density areas throughout both cerebral hemispheres with marked dilatation of the now undisplaced lateral ventricles (V). This demonstrates the severe intracranial injuries that can occur and the extensive permanent brain damage that can result from child abuse.

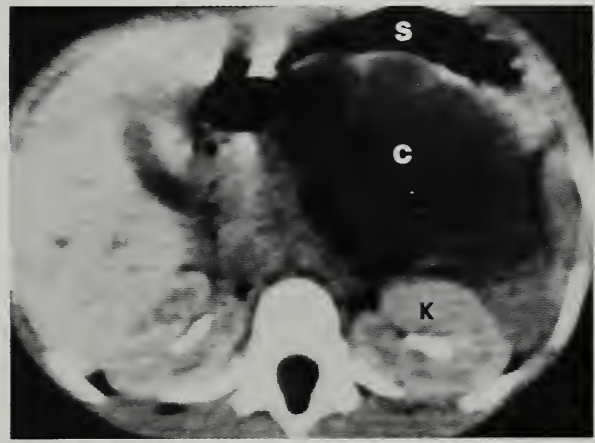


FIGURE 5: This 6-year old girl presented with an abdominal mass. An abdominal computed tomography showed a low density mass (C) resting behind the stomach (S) and in front of the left kidney (K). A diagnosis of pseudocyst of the pancreas was confirmed at surgery and a history of child abuse with abdominal trauma, occurring ten weeks earlier, was obtained.

teomyelitis, on the basis of localized swelling and tenderness of the limb. Frequently, a single traumatic episode is documented and x-rays are requested to exclude a simple fracture. Regardless of the reason for the examination, one of the radiologic patterns described above may be encountered or suspected. If so, the radiologist should take the liberty of doing the complete skeletal survey as previously outlined. If multiple fractures of varying age are demonstrated, the diagnosis of child abuse will be almost certain. In

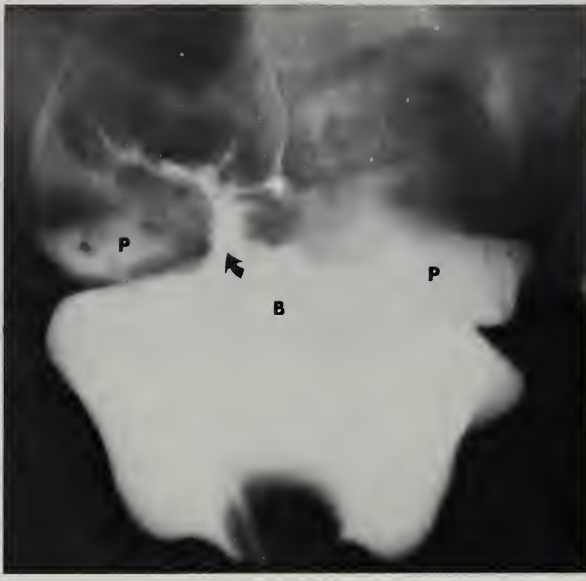


FIGURE 6: This 4-month female presented with listlessness and fever, but no history of trauma. An elevated blood urea nitrogen led to the urinary tract investigation and subsequent demonstration of bladder rupture by cystography. The contrast media leaks from the bladder (B) through a hole (arrow) into the peritoneal cavity (P). A diagnosis of child abuse was established.

fact, if the nature and severity of any traumatic lesion is out of proportion to the provided history of injury, the radiologist should exercise suspicion of abuse. Also, it should be remembered that the radiologist may be the common factor when a battered child is seen by different referring physicians after each episode of trauma. In these circumstances, he may suspect abuse simply by the inordinate number of requests for radiologic examinations for trauma.

Regardless of the basis for his suspicions, the radiologist is obliged to transmit them to the referring physician. Frequently, however, the attending doctor may be inclined to regard the radiologist's report with disbelief and may hesitate to act in the best interest of this patient. For this reason, in our hospital and most hospitals, there is a "child abuse committee" composed of concerned physicians and other personnel. When a suspect case of child abuse is picked up by the radiologist, the name is passed to the "committee," who will report the case and initiate the investigation. The radiologist or attending clinician can communicate with the Department of Social Services, Child Protection Division directly, if such a committee is not available. Remember, a physician need only be suspicious, is obliged to report these suspicions and is protected by law from subsequent litigation.

After a diagnosis of child abuse is established, the radiologist may find himself involved in subsequent legal proceedings as an expert witness. His testimony concerning the nature of the skeletal lesions, their mechanism of development, and their age may be critical to the outcome of the case. Since the radiologic changes of trauma provide one of the single best tests of a causal agent in pediatrics, the radiologist can be definite about the presence of fractures and related traumatic lesions. However, he can only guess as to their mechanism of development, that is by direct blow, twisting, bending, shaking, or some other injuring force. Because of the great variability in fracture healing, the exact age of individual fractures cannot be estimated with precision. The radiologist can recognize, however, that several fractures in an individual are at varying stages of healing and this can be the most incriminating evidence in the proceedings.

Thus the radiologist plays an important role, sometimes the most important role in the recognition and subsequent management of abused children. □

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SCMA

NEWSLETTER

December, 1985

SPECIAL SESSION: HOUSE OF DELEGATES

Approximately 250 physicians and guests were present on November 17, 1985 at the first called special session of the SCMA House of Delegates in 20 years. According to SCMA President, J. Gavin Appleby, M. D., *"a sense of unity and purpose"* surrounded the atmosphere at the Ellison Building at the State Fairgrounds in Columbia.

James H. Sammons, M. D., Executive Vice President of the American Medical Association, addressed the assembly on the professional liability situation nationwide and efforts by various states to solve the problem. In closing his remarks, he stated that *"it is imperative to the future of medical care in this country that the current crisis of excessive and non-meritorious lawsuits be tempered with reason and justice. Justice not only for patients...but for physicians as well."*

Delegates discussed the provisions of the Tort Reform legislation to be introduced in the South Carolina General Assembly in its upcoming session. Senators Bill Doar and Hugh Leatherman and Representative Jean Toal voiced their support of this legislation.

ASSESSMENT APPROVED

Following the above addresses and meeting as a "Reference Committee of the whole," Delegates, non-members and guests discussed a Resolution submitted by the SCMA Board of Trustees, after which the House of Delegates re-convened and unanimously approved the following:

RESOLVED, That the House of Delegates of the South Carolina Medical Association, by unanimous action, declare that a professional liability crisis exists in South Carolina; and

BE IT FURTHER RESOLVED, That all SCMA members in the state be assessed One Hundred Dollars (\$100.00) and all non-members be billed to create a Tort Reform Fund to finance a public and legislative campaign to correct this insalubrious condition.

Since that time, a special letter from the President has been mailed, and funds are currently being received at SCMA Headquarters in response. The SCMA Board of Trustees has approved a budget for the Tort Reform effort, which includes a public awareness and media campaign.

Each Trustee on the Board is attempting to arrange a special meeting of the county medical societies in his District to explain the legislation and begin a "grass roots" effort. If your county society does not have such a meeting scheduled in the next two months, contact your representative on the Board.

FLORENCE COUNTY MEDICAL SOCIETY UNITES IN TORT REFORM EFFORT

At its meeting on November 26, 1985, the Florence County Medical Society voted unanimously to donate the excess monies in its 1985 budget to the Tort Reform effort. This demonstration of the unity of the medical profession on the issue of professional liability is an outstanding illustration of the role of the federation of medicine in expanding your individual influence and presenting a united voice!

AMA'S PROFESSIONAL LIABILITY BILL

...has been introduced by Senator Orrin Hatch (R, Utah). Senators Daniel K. Inouye (D, Hawaii) and James Abdnor (R, S. D.) are co-sponsors.

The bill would provide federal grants as incentives for states to adopt designated tort reforms, such as mandating periodic payments for awards of future damages exceeding \$100,000; eliminating the collateral source rule; limiting non-economic damages, such as damages for pain and suffering, to \$250,000; and creating a decreasing sliding scale for attorneys' contingency fees. Also, a state would have to adopt additional peer review and disciplinary reforms, such as risk management programs conducted by insurance programs and mandatory for insured physicians.

Many of these provisions are included in the SCMA proposed legislation, to be pre-filed this month.

PROPOSED TORT REFORMS

...could save \$1 billion in professional liability costs in 1986, according to an actuarial analysis that was commissioned by the AMA. Without the tort reforms, the nation's physicians will pay more than \$3.6 billion in premiums next year, the consulting actuarial firm of Milliman & Robertson, Inc., New York, said in its report. Meantime, professional liability costs, including the costs of premiums, defensive procedures, attorneys' fees, and uncompensated time away from the practice because of litigation, increased by \$2 billion in 1984 alone, according to the AMA Center for Health Policy Research. The \$2 billion increase is equivalent to 2.7% of total expenditures on physicians' services during the year. Most of the cost associated with professional liability is apparently caused by defensive medicine.

PRESIDENT-ELECT ELECTED

The assumption of the Presidency by *J. Gavin Appleby, M. D.*, created a vacancy in the office of President-Elect. Because of the increased activities expected in the Legislature with the Tort Reform Bill, it was felt that a President-Elect was necessary to provide the assistance needed.

The House of Delegates, on November 17, approved two Amendments to the SCMA Bylaws to allow for this election to take place. By special ballot, *Walter J. Roberts, Jr., M. D.*, was subsequently elected. Dr. Roberts is an Internist in private practice in Columbia. He has previously served as Vice Speaker and Speaker of the House of Delegates, and will assume the Presidency of the Association following the completion of Dr. Appleby's term.

After having been sworn in, Dr. Roberts stated that this was one of the high points of his life. He said, "I'm gratified, I'm grateful, and I pledge to you that I will try to do as good a job as I possibly can."

RISK MANAGEMENT SEMINAR: FEBRUARY 5, 1986

By the time you receive this *Newsletter*, you should also have received a letter from *Euta M. Colvin, M. D.*, Chairman of the Risk Management Subcommittee of the Professional Liability Committee. This letter announces an important Risk Management Seminar planned for WEDNESDAY, FEBRUARY 5, 1986 in Columbia at the Sheraton Northwest at I-20 and Bush River Road.

The Seminar, scheduled for 9:00 a.m. until 4:00 p.m. will feature a theme of "Professional Liability -- What's Next?" Major speakers will be:

James S. Todd, M. D., Senior Deputy Executive Vice President of the American Medical Association,

Mr. Adam Wilczek, Vice President for Risk Prevention of the Medical Interinsurance Exchange of New Jersey, and

Mr. James Lewis Griffith, Esq., Philadelphia defense attorney.

A "Dutch Treat" luncheon will feature *Mrs. J. D. (Margaret Ann) Ashmore* of Greenville, who will discuss the importance of establishing malpractice support groups in local communities. The afternoon program will include an update on the legislative status of the SCMA Tort Reform Bill.

There is no registration fee. WATCH FOR REGISTRATION MATERIALS EARLY NEXT MONTH AND RESERVE THIS DAY TO COME TO COLUMBIA FOR THIS TIMELY AND IMPORTANT PROGRAM.

BILLIE BRADY RECEIVES ORDER OF THE PALMETTO

Mrs. Wayne C. (Billie) Brady has been awarded "The Order of the Palmetto" in recognition of her service to South Carolina during her tenure as President of the American Medical Association Auxiliary.

Governor Riley presented this award at a reception given in Mrs. Brady's honor at the Governor's Mansion on November 22, 1985. "The Order of the Palmetto" is the highest honor which can be bestowed by the Governor.

THE IMPORTANCE OF SCMA MEMBERSHIP!

With all of the major issues facing the medical profession today, such as the liability crisis outlined in this *Newsletter* and elsewhere, it is more important than ever that every physician in South Carolina become involved in county, state and national medical associations.

A second membership appeal has just been sent to those physicians who have not yet responded. *Charles R. Duncan, Jr., M. D.*, Chairman of the SCMA Board of Trustees, urges all physicians to "unite to maintain our position and move ahead to accomplish our goals."

In 1985, SCMA membership increased nearly seven percent (7%) -- if that trend continues, we will be a much stronger organization to face the problems of the present and the challenges of the future. JOIN TODAY!

HOME HEALTH SERVICE

The AMA has requested that we communicate the following Resolution to our membership. This Resolution, adopted by the AMA House of Delegates at its 1985 Annual Meeting, was motivated by concern for assuring that the services provided to any patient by a home health agency are only those adjudged appropriate to the patient's needs by a physician involved in that patient's care.

RESOLVED, That the American Medical Association call upon the nation's physicians to write or carefully review all initial and renewal orders for home health services and approve only those that are medically indicated; and be it further

RESOLVED, That the AMA urge physicians to report to appropriate payment agencies and regulatory authorities cases of abusive practices by home health agencies; and be it further

RESOLVED, That the AMA urge physicians not to authorize the provision of home health services to any patient with whom he or she is not professionally involved in providing care.

CAPSULES....

....Honorary membership status has been granted to *Henry W. Rittenberg, M. D., Charleston*; *James A. Underwood, M. D., Newberry*; and *Gordon T. Wannamaker, M. D., Charleston...*

....*Steven N. Coker, M. D., Florence*, is the SCMA representative on the newly-created Governor's Task Force on Prevention of Teenage Pregnancy.

...The new President of the S. C. Chapter, American Academy of Family Physicians, is *Waitus O. Tanner, M. D., Columbia*, SCMA Delegate to the American Medical Association and former SCMA President. *Pam M. Snape, M. D., Greenville*, is President-Elect, and *Mack C. Poole, M. D., Spartanburg*, is Chairman of the Board.

VIDEOTAPES AVAILABLE

The proceedings of the November 17, 1985 special called session of the SCMA House of Delegates are available on videotape and can be provided for special showings on loan from Headquarters. Other videotapes available include:

The Risk Management Seminar presented at the 1985 Annual Meeting in Charleston;

The Professional Liability Teleconference shown throughout the state at selected hospitals in February, 1985;

"Growing Up," a videotape series produced by the SCMA Committee on Perinatal and Maternal Health and the State Department of Education; and

"Patients are People, Too," produced by the SCMA Subcommittee on Risk Management.

Contact SCMA Headquarters to inquire about showing any of the above tapes in your area.

FLEXIBLE FIBEROPTIC SIGMOIDOSCOPY: INDICATIONS AND BENEFITS FOR THE OFFICE-BASED PRACTICE*

FREDERICK L. GREENE, M.D.**

Endoscopy itself is not a new technique, but has only gained a significant following since the advent of flexible fiberoptic methods which have transformed gastrointestinal endoscopy from a modality having limited access to one which allows the entire upper and lower gastrointestinal tracts to be directly visualized. The term endoscopy itself comes from the ancient Greek (*Endo*, meaning within and *Skopeo*, meaning to examine). In the late 1960s, the technology of fiberoptics was born and was eventually applied to endoscopy, which in 1985, has resulted in a wide variety of instrumentation.

Flexible fiberoptics have been especially beneficial to the examination of the distal portion of the colon and rectum in that a simple method of examining this region with the flexible fiberoptic sigmoidoscope can now be achieved. This technology has not only benefited the physician, but, more importantly, has made ease of examination much more appealing to patients who previously had no choice but to endure the rigors of the rigid sigmoidoscope. Today, when organizations such as the American Cancer Society are fostering early diagnosis and public education, the ability of physicians to apply the technology of flexible fiberoptic sigmoidoscopy to their practice is more important than ever. The principles of fiberoptic endoscopy are based on the concept that light energy can be transmitted through fiberoptic bundles and can be delivered as a "cold light" source with a series of fiberoptic imaging bundles that are available to transmit images back to the examiner. While the technique of colonoscopy

involves the introduction of a 180 centimeter instrument which is both time consuming and more difficult for the patient, the shorter 65 centimeter, flexible fiberoptic sigmoidoscope has been developed as a basic diagnostic tool which can be applied in any situation where screening of patients or symptom resolution is important.

For the physician seeing patients in the office, the flexible sigmoidoscope can be used in a variety of situations and potentially can allow an examination of at least twice the length of rectosigmoid colon that was previously made possible by the rigid instrument. Most physicians will find that flexible sigmoidoscopy is used primarily for symptom resolution in patients who present with symptoms including constipation, hematochezia, diarrhea, or abdominal pain. Other indications for flexible fiberoptic sigmoidoscopy include follow-up studies on patients with previous polyps or large bowel cancer and routine screening of patients who are members of families at increased risk for colorectal cancer. Although radiologic procedures, especially the air-contrast barium enema, continue to have an important role in the diagnosis of colorectal disease, the flexible fiberoptic sigmoidoscope should be used in conjunction with these procedures and probably should be done prior to planned barium enema. The flexible fiberoptic sigmoidoscope may also be used easily in patients who have an abdominal stoma since the flexible characteristics of the instrument will allow easy intubation of the stoma and generally a complete examination of the entire colon.

Preparation of the patient can be achieved with a high degree of success using two enemas administered at least one hour prior to the examination. Cleansing of the colon and clear liquid diet are not necessary prior to sigmoidoscopy. The examination is performed easily using the lateral decubitus (Sims) position which allows both for patient and examiner comfort. Standard prone and knee-chest positions may be used, but should be limited

* Presented as a "Workshop on Flexible Fiberoptic Sigmoidoscopy" at the Annual SCMA Meeting, April 25, 1985, Charleston, S. C.

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SIGMOIDOSCOPY

since these positions do not add appreciably to the examination. Digital rectal examination should always be performed prior to introduction of the flexible sigmoidoscope in order to assess significant disease of the anal canal or distal rectum. The instrument should always be checked carefully to assure that the air and suction channels are working properly prior to intubation of the rectum. When inserting the instrument, gentle compression of one wall of the anal canal with the index finger helps to avoid any undue trauma to this region, especially in patients with internal hemorrhoidal disease.

The goal of flexible sigmoidoscopy is to achieve optimum intubation distance under direct vision with the aim of examining the entire distal colon and rectum during withdrawal of the instrument. As is true for any endoscopic technique, visualization of the lumen of the colon should be maintained at all times while avoiding the introduction of the instrument in a blind fashion.

Only through experience and practice can the proper hand-eye coordination be achieved to allow easy intubation of the distal colon and rectum. Recognition of characteristic disease processes will only be achieved through experience, especially that gained while performing endoscopic procedures with an experienced instructor. The ideal goal is to advance the entire length of the sigmoidoscope without causing any redundancy of the endoscope. Once the entire instrument has been advanced, the examination is done in a slow, methodical method looking at the entire circumference of the colon and rectum while slowly withdrawing the instrument. Although the flexible sigmoidoscope is not primarily a therapeutic instrument, the ability to biopsy lesions will enhance the diagnostic capability of the instrument and can be achieved using the biopsy forceps supplied by the manufacturer for each particular flexible instrument.

While the complication rate for flexible sigmoidoscopy is low, it should be remembered that perforation can occur through blind intubation as well as over insufflation with air. It is advised that only the smallest amount of air be used in order to distend the colon for easy visualization and intubation. The examiner must learn to recognize diverticular disease which is present in most of our elderly patients and to assure that a large-mouthed diverticulum is not mistaken for the lumen of the bowel which can result in possible

perforation. Similarly, the biopsy forceps must always be advanced slowly and gently while visualization of the forceps is maintained during biopsy.

After appropriate training in the technique of flexible fiberoptic sigmoidoscopy, the examination can generally be performed within 10 to 15 minutes. The examination may be more difficult in patients with previous abdominal or pelvic surgical procedures since adhesions cause fixation of the distal sigmoid colon and do not allow for easy intubation or distention with air. Since routine sedation is not needed during this examination, the patient will usually complain when excessive stretching of the gut is occurring and, at this point, the examiner should withdraw the instrument to a more proximal location and then proceed with intubation in a gentle fashion.

Although there are few contraindications to this examination, flexible fiberoptic sigmoidoscopy should not be performed in the patient with excessive bleeding from the rectum since the ability to suction and to visualize the lumen will be severely compromised. Similarly, in patients who have clinical evidence of ischemic disease of the distal colon, flexible sigmoidoscopy must be undertaken with extreme caution since the bowel may be extremely friable and more susceptible to perforation.

Flexible fiberoptic sigmoidoscopy should become a standard technique for any physician who cares for patients who are susceptible to colorectal disease. Recent information regarding the changing distribution of colorectal cancer indicates that a larger percentage of patients may develop cancers in a more proximal location in the colon, therefore, requiring a more complete endoscopic evaluation than formerly achieved using the 25 centimeter rigid sigmoidoscope. This "left to right shift" in large bowel cancer is especially evident in patients over the age of 60 and in the female population.¹ Practitioners who treat older patients would, therefore, benefit by adopting this technique to their population of patients. The initial cost of the flexible sigmoidoscope is a factor which must be taken into account by any physician determined to add this to his or her armamentarium of office procedures. Because of the delicate nature of these instruments, additional cost will be incurred if damage results from improper cleaning techniques and, therefore, the physician has the responsibility of maintaining adequate

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care for this equipment. It is recommended that office personnel be identified who will help with the maintenance and cleaning of these instruments to avoid improper handling and the resulting high cost of repair. Proper infection control must also be maintained when using the flexible sigmoidoscope. While generally the instrument may be cleaned rapidly using standard disinfectant solutions, appropriate cleaning of the instrument, especially using prolonged liquid or gas sterilization, may be necessary when patients are examined who have any possibility of infectious diarrhea or hepatitis. Similarly, since intubation of the colorectum will generally produce a bacteremia in most patients, those individuals with prosthetic devices in the heart or vascular system

must be covered with the appropriate antibiotic techniques to avoid a potential infectious complication.

The use of flexible fiberoptic sigmoidoscopy in the office will be a rewarding experience to both patient and physician alike if the proper indications, contraindications, and technical considerations are kept in mind. As is true in any application of a new technique, the time spent in understanding the principles and working with those who are knowledgeable of these procedures will return dividends that will last the physician throughout his or her career. □

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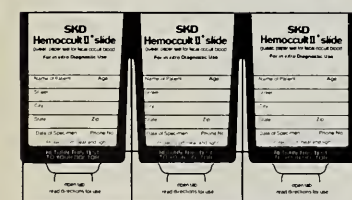
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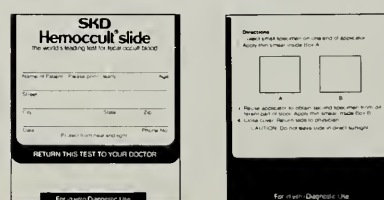
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OBSTRUCTIVE SLEEP APNEA: DIAGNOSIS AND TREATMENT*

WILLIAM R. COOK, M.D.**
J. DAVID OSGUTHORPE, M.D.

CLINICAL FEATURES

Although descriptions of what is now recognized as obstructive sleep apnea syndrome (OSA) have existed in the medical literature for over 100 years, widespread interest in the problem has developed only over the last 15 to 20 years. While considerable insight has been gained into the clinical features and pathophysiology of OSA, the incidence of the disorder is unknown. OSA is thought to be a common problem, however, especially among overweight males with a history of loud snoring, a group that comprises about 20 percent of the adult population. The incidence among females is substantially lower. The treatment of OSA has been the subject of intense research interest over the last 10 years, and while a number of promising forms of treatment have been described, long term controlled studies designed to judge the efficacy of treatment are lacking at this time. This paper will review the clinical features of OSA and outline the treatment as it presently exists.

Among the characteristic features of OSA listed in Table I, excessive daytime sleepiness and loud disruptive snoring most frequently result in a patient's consultation with a physician. Patients with daytime hypersomnolence may complain of the need to "fight sleep" throughout the day and may actually fall asleep at inappropriate times, such as during a conversation, business transaction, or while driving an automobile. Occasional patients with severe apnea have been known to sleep continuously during the day, to awaken only during intense stimulation, and to resume sleep immediately after cessation of stimulation. Loud

intermittent snoring is a frequent complaint, with noisy disruption of the sleep of both patient and others in his vicinity. The spouse of patients suspected of OSA should always be interviewed as a part of the history-taking process, as he or she frequently has observed and can describe periods of apnea alternating with periods of snoring. Frequently, sleep will be disrupted by the patient's abnormal thrashing; this history of abnormal motor activity can be obtained only through a careful interview with both the patient and spouse.

Less than one-half of patients with OSA suffer from morbid obesity. A history of increased resistance to breathing through the nares is extremely common, and evidence for nasal obstruction in the form of nasal septal deviation, nasal mucosal edema from inhalant allergies or vasomotor rhinitis, and polyp formation may be present. The other physical findings listed in Table I are less common but should not be overlooked.¹

Routine laboratory tests are of little value in

Table I
COMMON CLINICAL FEATURES OF OSA SYNDROME

SYMPTOMS

Excessive daytime sleepiness
Loud intermittent snoring
Abnormal motor activity during sleep
Psychological dysfunction
Morning headaches, enuresis, impotence

PHYSICAL FINDINGS

Obesity
Nasal obstruction
Elongation and redundancy of pharyngeal tissue
Short thick neck
Micrognathia
Features of hypothyroidism, acromegaly
Evidence of pulmonary hypertension
Systemic hypertension

LABORATORY FINDINGS

Polycythemia
Normal daytime blood gases usually
"Saw-Tooth" sign on flow-volume loop

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OSA; polycythemia and blood gas abnormalities are usually seen only in severe cases. Routine pulmonary function tests are of limited diagnostic value in OSA. A "Saw-Tooth" sign on the inspiratory or expiratory portion of the flow-volume loop has been reported to have diagnostic value in OSA.² While this is the only test known that has diagnostic value during wakefulness, the test is lacking in diagnostic accuracy. A negative test does not obviate the need for studies during sleep in the high risk patient. Spirometric testing may be desirable if underlying pulmonary disease or pulmonary dysfunction secondary to obesity is suspected. CT scanning is presently used on an experimental basis to localize the anatomic sites of pharyngeal obstruction and is not indicated in the routine evaluation for suspected OSA.

Diagnosis of OSA syndrome is confirmed when, in the presence of appropriate clinical symptoms and findings, the patient is shown to have multiple repetitive disordered breathing events, usually between 200 and 500 per night, by polysomnography. Polysomnography is the recording of multiple variables during sleep, including oral and nasal airflow, respiratory effort, electrocardiogram, and oxygen saturation. In addition, the polysomnogram usually includes the electroencephalogram (EEG) for the detection and staging of sleep. Polysomnography preferably should be performed throughout a full night of sleep. The four basic types of disordered breathing event detected by polysomnography are shown in Figure 1. Obstructive apnea, the most common breathing disturbance, is diagnosed when there is apnea, defined as absence of oral or nasal airflow for 12 seconds or longer, in the presence of respi-

ratory effort. While respiratory effort is detected in this illustration by fluctuations in esophageal pressure, external strain gauges and inductive plethysmography are non-invasive methods that allow satisfactory detection of respiratory effort in most cases. Apnea coupled with the absence of respiratory effort is called central apnea. Mixed apnea is diagnosed when, during the course of a period of absent airflow, lack of respiratory effort is followed by the appearance of evidence of diaphragmatic contractions. Hypopnea is similar to obstructive apnea, with the observation of reduced rather than absent airflow in the presence of respiratory effort. The majority of patients with OSA show a predominance of obstructive apnea and hypopnea during sleep, with lesser percentages of mixed and central apnea. A small percentage of patients present with predominantly central apnea associated with daytime fatigue.¹

PATHOGENESIS

The site and mechanism of airway obstruction in obstructive apnea was first delineated in 1979 when the site of obstruction was shown to lie between the nares and the vocal cords.³ When airway pressure in the pharynx falls during inspiration, there is a normal tendency for the soft tissues of the pharynx to collapse. The upper airway pharyngeal dilator muscles, shown in Figure 2, normally contract synchronously with the diaphragm and intercostal muscles and are thought to prevent pharyngeal collapse during

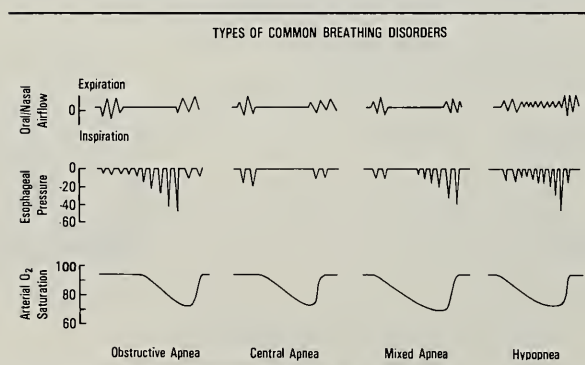


FIGURE 1. This drawing illustrates the patterns of oral/nasal airflow (in liters/minute), respiratory effort (expressed as esophageal pressure in cm H₂O) and arterial oxygen saturation (in % units) that occur during four types of disordered breathing.

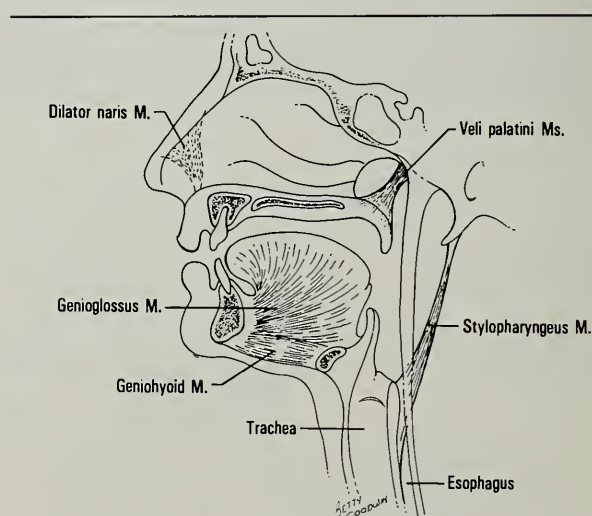


FIGURE 2. This drawing of a lateral view of the upper airway shows the approximate position of those muscles that maintain patency of the airway during inspiration.

inspiration. Apnea is thought to occur when the action of the upper airway muscles, normally decreased during sleep, fails to counteract the effect of contraction of the diaphragm and intercostal muscles during inspiration. Once the airway collapses, airway pressure becomes increasingly negative as the patient makes greater and greater inspiratory efforts, and airway obstruction persists until arousal occurs, accompanied by a massive contraction of the upper airway muscles. The patient with OSA may undergo periods of obstruction followed by arousal several hundred times during a night. Excessive daytime sleepiness probably results from fragmentation of sleep secondary to multiple arousals. Additionally, patients with OSA generally are found to have abnormal sleep architecture, spending an increased percentage of their sleeping hours in Stage 2 of non-REM (rapid eye movement) sleep, at the expense of time normally spent in Stages 3 and 4 of non-REM sleep. The percentage of time spent in REM sleep is usually normal.¹

Factors that contribute to the development of OSA fall into three categories: (1) those that facilitate pharyngeal collapse through reduction in pharyngeal size, (2) those that interfere with the balance between upper airway muscle and diaphragmatic/intercostal function and (3) those that increase upper airway resistance with resulting greater negativity of airway pressure during inspiration.⁴ Examples of conditions that compromise pharyngeal size anatomically include obesity with increased deposition of fat around the airway, hypothyroidism, in which the tongue and pharyngeal tissues are increased in bulk, and micrognathia, in which the lower jaw is displaced posteriorly with compromise of the pharyngeal lumen. Alcohol ingestion has been associated with imbalance of muscle function, with selective depression of the upper airway muscles without loss of diaphragm and intercostal function. Alcohol has been shown to induce apnea in males with a history of loud snoring who did not ordinarily have apnea and to increase the frequency of apnea in males with known sleep apnea. Sedative drugs may induce sleep apnea through a similar mechanism.⁵ The most significant factor that induces apnea by increasing upper airway resistance is nasal obstruction of any cause, most commonly nasal fracture, nasal septal deviation and allergic rhinitis and sinusitis, with nasal obstruction secondary to edema of the turbinates

and nasal polyp formation.⁶

TREATMENT

Treatment of OSA involves a number of approaches, including: (1) correction of contributing factors; (2) direct surgical intervention to eliminate or bypass pharyngeal obstruction; and (3) splinting of the upper airway during sleep using continuous positive airway pressure (CPAP). An aggressive weight reduction program is indicated for those who have massive obesity as a contributing factor. The exact amount of weight that obese patients must lose in order to correct their problem is unknown. There is evidence that in some patients a threshold weight exists below which sleep apnea resolves or greatly improves. Correction of contributing factors includes advice to the patient concerning the avoidance of alcohol and sedative drugs, particularly in the evening hours just prior to sleep, and also includes the diagnosis and treatment of endocrine conditions such as hypothyroidism, acromegaly or exogenous androgen ingestion in body builders, all known to induce or aggravate OSA.

Surgical correction of contributing factors includes nasal septoplasty for severe nasal septal deviation, since nasal obstruction causes increased nasal resistance and necessitates increased negativity of airway pressure. Since inhalant allergies may lead to enlargement of the turbinates and the development of nasal polyps, a combination of hyposensitization therapy and nasal polypectomy may lead to a marked reduction in OSA in selected patients.

Surgical intervention to eliminate or bypass pharyngeal obstruction is necessary for life-threatening OSA and is frequently beneficial in moderately severe cases that are poorly responsive to medical therapy. Tracheostomy is the sole predictably successful treatment, but this procedure is usually reserved for patients in whom there is an immediate threat to life, with sustained oxygen desaturation, profound sinus bradycardia or other significant arrhythmia, and cor pulmonale.⁷ Most individuals treated with tracheostomy return to normal activities within one to two months of surgery. They need only to unplug the tracheostomy before sleep to eliminate obstructive apnea. Daily stoma hygiene is required in patients with tracheostomy, however, and severe psychosocial problems may arise.

A careful examination of the nose, mouth, pharynx and larynx usually identifies patients in whom less aggressive intervention than tracheostomy might afford significant improvement in symptoms. Children with very enlarged tonsils or adenoids which impede respiration usually benefit dramatically from tonsillectomy and/or adenoidectomy. Adults are evaluated with particular attention to differentiating nasal and oropharyngeal from hypopharyngeal nocturnal airway obstruction. A majority of OSA (and snoring) originates in the lower nasopharynx and oropharynx where redundant soft palatal, uvular and tonsillar tissues collapse into the airway during inspiration.⁷ This excess tissue is frequently evident on routine oral examination, but diagnostic accuracy is improved by transnasal flexible fiberoptic inspection of the airway in the supine patient. Approximately 50 to 75 percent of patients with nasopharyngeal and oropharyngeal obstruction will have relief of symptoms with uvulopalatopharyngoplasty (see next article). A significant hypopharyngeal component to obstruction is present in one-third of patients, who usually have small or retrodisplaced mandibles, large tongues and inferiorly displaced hyoid bones. The larynges of these individuals are difficult to visualize by mirror examination, and flexible fiberoptic examination in the supine position frequently demonstrates posterior displacement of the base of the tongue towards the posterior pharyngeal wall during inspiration.

Aside from tracheostomy, no procedure is uniformly successful in these patients. Mandibular sagittal osteotomy or expansion hyoidoplasty to widen the hypopharynx and shift the tongue anteriorly have been advocated; however, the data supporting these procedures are as yet insufficient, and morbidity may be great.⁸

Splinting of the upper airway during sleep using CPAP, first described by Sullivan in Australia in 1981, is the most promising form of medical therapy available at this time.⁹ The patient sleeps in the laboratory overnight, with a tight-fitting mask in place over the nares, and a level of positive pressure that abolishes apnea is determined. The patient then sleeps every night with his mask in place. He uses the mask indefinitely or until he has definitive therapy. Nasal CPAP has the advantages of low initial cost, no known morbidity, and almost complete abolishment of both obstructive apnea and snoring. A major disadvantage of nasal CPAP is the requirement that the mask must be utilized every night in order to be effective. Nasal CPAP is poorly tolerated or not accepted at all by approximately 20 percent of patients.

The utility of drug therapy for treatment of OSA remains to be established. Medroxyprogesterone acetate therapy was shown to have possible benefit in one publication and no benefit in another. Protriptyline reduces time spent in REM sleep and, thus, may be of value in treating a small percentage of patients whose apnea is pri-

Table II
TREATMENT OF OSA SYNDROME

<i>Degree of Severity</i>	<i>Characteristics</i>	<i>Treatment</i>
MILD	Patient abnormally sleepy but functional Greater than 4 apneas/hour O ₂ saturations generally > 85% during apnea No significant cardiac rhythm disturbance	Weight reduction if indicated Avoid alcohol and sedative drugs Correct other precipitating problems nasal obstruction hypothyroidism, acromegaly micrognathia hypertrophied tonsils and adenoids
MODERATE	Sleepiness with increased risk of injury Multiple apneas lasting > 30 seconds O ₂ saturations 60-85% during apnea Cardiac arrhythmias, not life-threatening	Treatments for mild apnea apply UPP if obstruction is naso/oropharyngeal Nasal CPAP if obstruction is hypopharyngeal if UPP has not been helpful if the patient declines surgery
SEVERE	Profound sleepiness, poor quality of life Multiple apneas lasting > 30 seconds Oxygen saturation < 60% on a prolonged basis Profound cardiac rhythm disturbances	Tracheostomy if immediate threat to life exists If no threat, treat same as moderate severity

SLEEP APNEA

marily associated with REM sleep. Evidence that oxygen therapy might benefit some patients has been reported, but additional studies are needed to determine those patients likely to improve.⁴

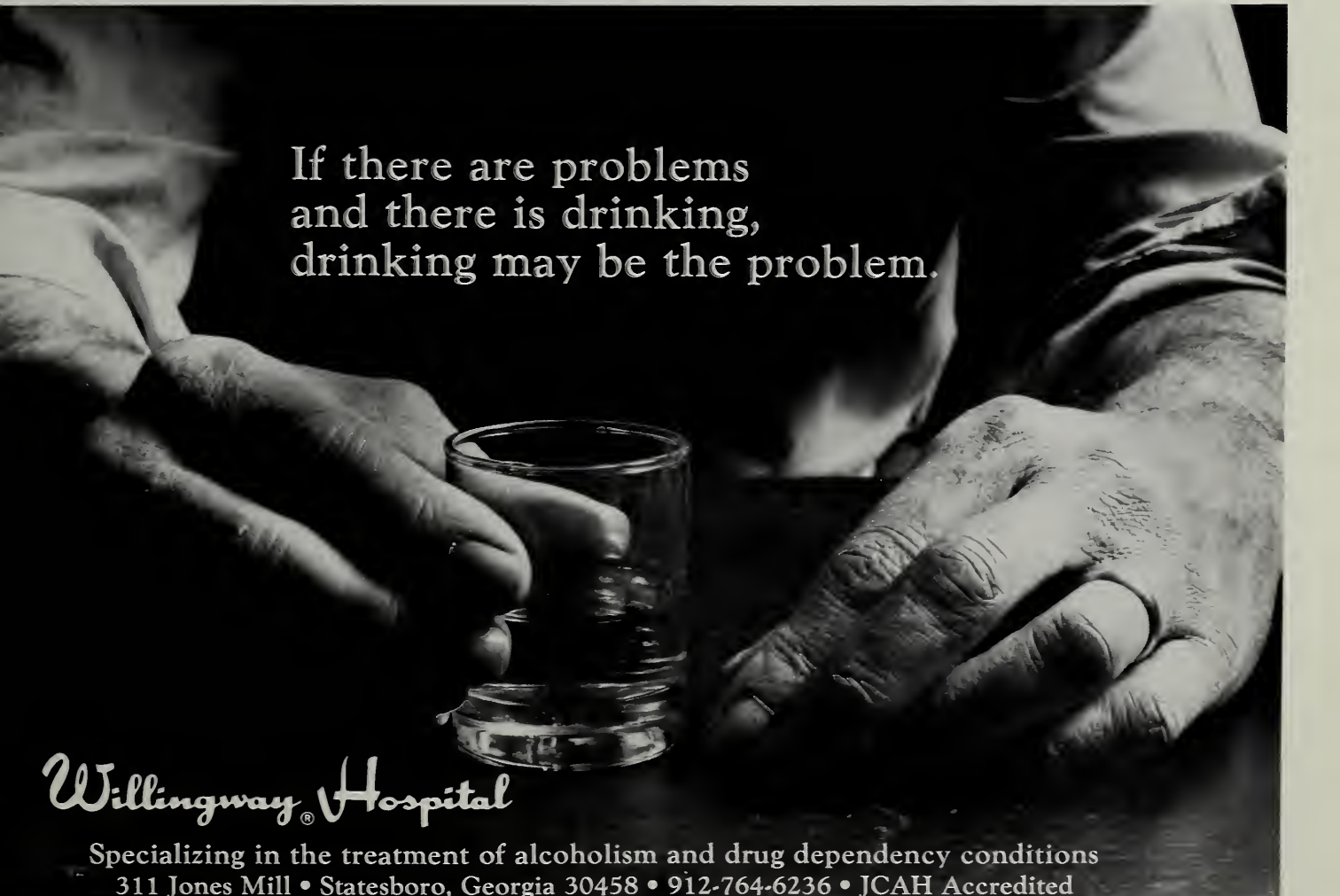
A general approach to the treatment of OSA, based upon the degree of severity of the problem, is presented in Table II. The patient with mild OSA syndrome should be given advice concerning weight reduction, cautioned against alcohol and sedative drug use before sleep, and should receive treatment for the contributing factors listed. The patient with moderately severe OSA should receive the same treatment as the lesser affected patient plus either surgery to correct upper airway obstruction or nasal CPAP therapy. The patient with severe problems should receive tracheostomy if there is an immediate threat to life; otherwise, the treatment recommended for moderate severity should be employed.

While many advances have been made in the diagnosis and treatment of OSA, further studies are needed to define the best forms of therapy. Until controlled, long-term studies on the use of oxygen, drugs and the various surgical procedures

become available, all patients suspected of having OSA should receive a careful clinical evaluation that includes polysomnography. Treatment plans for patients should be individualized with primary consideration given to the least invasive forms of therapy. □

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UVULOPALATOPHARYNGOPLASTY FOR SLEEP APNEA

J. DAVID OSGUTHORPE, M.D.*

ROBERT C. JORDAN, M.D.**

AUGUSTUS J. GOFORTH, III, M.D.***

Uvulopalatopharyngoplasty (UPP) was introduced in 1981 for amelioration of obstructive sleep apnea (OSA) of oropharyngeal origin.¹ It should be considered in patients with moderate sleep apnea problems such as nocturnal oxygen saturations persistently below 85 percent, impotence, hypertension and daytime somnolence causing socioeconomic difficulties. UPP can be performed in conjunction with tracheostomy for life-threatening OSA and allows a later decannulation in 50 percent of patients when used in conjunction with weight reduction and/or medical therapy. UPP can also ameliorate snoring in carefully selected patients with very loud, disruptive snoring, of which one-third have an undiagnosed sleep apnea problem. The criteria for identifying patients who will benefit from UPP are the subject of continuing research, but a polysomnographic sleep study and a physical examination are recommended for all patients.^{2, 3} UPP is effective only when the primary nocturnal airway blockage is in the oropharynx. These patients typically have a low palatal arch, and redundant soft palate, uvula, tonsil and posterolateral oropharyngeal tissues. Though these findings can be evident on peroral examination, a transnasal flexible fiberoptic examination of the oropharynx with the patient in a supine position frequently verifies the inward collapse of these tissues into the airway during inspiration. Patients with concomitant deviation of the nasal septum should be corrected before or at the time of UPP. While a majority of OSA originates in the oropharynx, approximately 36 percent of patients have a significant hypopharyngeal component to the nocturnal airway insufficiency. Such patients usually have some

combination of a large tongue, small or retro-displaced mandible, inferiorly displaced hyoid and short, thick neck. Unfortunately, it is not always possible to pinpoint the principal anatomic site of obstruction as oropharyngeal or hypopharyngeal, and this probably accounts for the unsuccessful UPP operations. Cephalometric radiographic evaluation, computed tomographic examination of the pharynx and larynx with the patient in the supine position and videofluoroscopy during the polysomnographic sleep studies have been advocated and may improve diagnostic accuracy.

The basics of UPP are outlined in Figures 1 and 2. The procedure is usually performed under general anesthesia, and the morbidity and postoperative stay is similar to a tonsillectomy in adults without medical problems such as obesity and hypertension. The tonsils are removed, if present, or mucosa is removed from the tonsillar fossae. The posterior tonsillar pillars (palatopharyngeus muscles) are undermined, pulled anteriorly and sutured to the anterior pillars (palatoglossus muscles) (Fig. 1). Any remaining redundant mucosal folds in the posterolateral oropharynx are elipsed and removed. The posterior 5 to 10 mm of the soft palate is excised along with the uvula, and nasal floor mucosa is pllicated to the palatal mucosa to cover the raw posterior edge of the shortened soft palate (Fig. 2). Most patients have velopharyngeal insufficiency for one or two weeks postoperatively, as evidenced by occasional nasal regurgitation of liquids and hypernasal speech.⁴ These problems can persist in unusual instances and require revision surgery. A preponderance of patients report a marked decrease in snoring within a few weeks of the operation. While most also report subjective improvement in daytime sleepiness, polysomnographic study documents a greater than 50 percent improvement in the apnea index in only 50 to 75 percent of patients.¹⁻³

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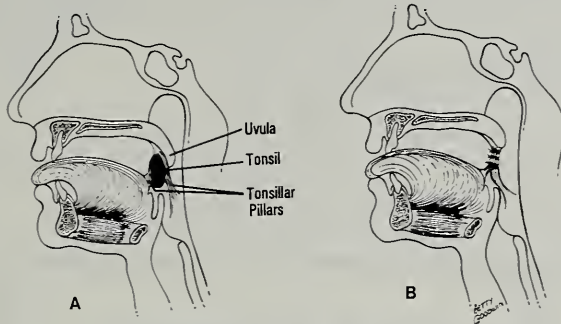


FIGURE 1. Sagittal diagrams of oropharynx before (A) and after (B) removal of posterior soft palate, uvula and tonsils with plication of tonsillar pillars to increase anteroposterior oropharyngeal airway.

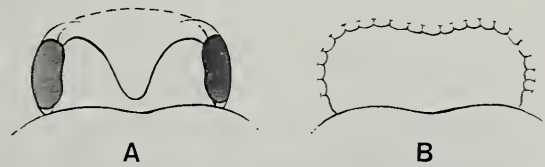


FIGURE 2. Posterior soft palatal arch, uvula and tonsils (or tonsillar fossa mucosa) are removed by U.P.P. to create a wider oropharynx. A = preoperative state, B = postoperative state.

Patients not objectively improved by UPP are re-evaluated with attention to the remaining soft palate and oropharyngeal tissues, and to potential nasal, hypopharyngeal/laryngeal or central nervous system components to the sleep apnea. □

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 American Cancer Society & Society of American Gastro-
 intestinal Endoscopic Surgeons
 CONTACT: Frederick L. Greene, M.D., (803) 776-4000, ext. 583
 or (803) 256-0308
 FEE: \$225

DESCRIPTION: This course is designed for practicing sur-
 geons who wish to learn the techniques and indications of
 Esophagogastroduodenoscopy (EGD) and Flexible Sigmoidoscopy. Surgeons who are already familiar with these
 techniques will have an opportunity for an update in the
 further application of these procedures as they apply to
 newer diagnostic and therapeutic maneuvers.

CME CREDIT: 11 House AMA Category I

GRAND ROUNDS

U.S.C. School of Medicine

2nd and 4th WEDNESDAYS 3:00-4:00
GASTROINTESTINAL RADIOLOGY CONFERENCE
COLUMBIA, VA Radiology Dept. Conference IC 209, VA Hospital
 SPONSOR: USC School of Medicine, Dept. of Radiology and Gastro-
 enterology and Division of Internal Medicine
 DESCRIPTION: One-half of the conference will be a discussion and film
 review of a specific subject. The second half will be devoted to cur-
 rent case material with both radiographic and endoscopic findings.
 AUDIENCE: Radiologists, Gastroenterologist and other interested
 physicians
 CONTACT: James J. Farrell, M.D., (803) 733-3295
 FACULTY: USC School of Medicine, Dept. of Radiology; Division of
 Gastroenterology, Internal Medicine and Guest Speakers
 CME CREDIT: 1 Hour AMA Category I per session

MONDAYS 7:00 A.M.
ORTHOPAEDIC GRAND ROUNDS
COLUMBIA, Richland Memorial Hospital - 1st Floor
 CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

MONDAYS 4:00 P.M.
BASIC SCIENCES SEMINAR SERIES
 CONTACT: Louis Terracio, Ph.D., (803) 733-3373

MONDAYS-THURSDAYS 12:00-1:00 P.M.
INTERNAL MEDICINE LECTURE SERIES
 Richland Memorial Hospital 7 West Classroom
 CONTACT: J. O'Neal Humphries, M.D., (803) 765-6563

2nd & 3rd MONDAY 12:30 P.M.
G.I. JOURNAL CLUB
 Dorn Veterans' Hospital Room 5A127
 CONTACT: John Orchard, M.D., (803) 776-4000 Ext. 673

MONDAYS, TUESDAYS, WEDNESDAYS, & THURSDAYS
12:00-1:00 P.M.

FAMILY PRACTICE CONFERENCE
COLUMBIA, Richland Memorial Hospital, Large Dining Room of the
 Cafeteria—Mondays—Family Practice Conference Room—Tuesdays
 and Thursdays

SPONSOR: Dept. of Family Practice, USC School of Medicine
 AUDIENCE: Family Practice and Internal Medicine Physicians and
 Medical Students

CONTACT: Roslyn D. Taylor, M.D., (803) 765-6118, Dept. of Family
 Medicine Richland Memorial Hospital, Columbia, SC
 FACULTY: Dept. of Family Medicine and Internal Medicine, USC School
 of Medicine
 CME CREDIT: 1 Hour AMA Category I per session

TUESDAYS 7:00 A.M.
BASIC SCIENCE & PATHOLOGY ASPECTS OF ORTHOPAEDICS
 Richland Memorial Hospital - Radiation Therapy Conference Room
 CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

3rd TUESDAY 12:30 P.M.
OB/GYN GRAND ROUNDS

COLUMBIA, Richland Memorial Hospital
 SPONSOR: USC Dept. of OB/GYN, RMH, MUSC, Spartanburg and
 Greenville

DESCRIPTION: One of a series of live interactive broadcasts over the
 HCN, a statewide closed circuit TV network for CME in OB/GYN.

CONTACT: Ronald B. Wade, M.D., (803) 765-7156

FEE: None

CME CREDIT: 1 Hour AMA Category I (per session)

FRIDAYS 8:00 A.M.
PEDIATRIC GRAND ROUNDS

COLUMBIA, Richland Memorial Hospital
 SPONSOR: USC School of Medicine, Dept. of Medicine
 CONTACT: Warren Derrick, M.D., (803) 765-7211
 CME CREDIT: 1 Hour AMA Category I (per session)

WEDNESDAY 12:00 NOON
PSYCHIATRY GRAND ROUNDS
 Hall Institute Form
 CONTACT: Bonnie Ramsey, M.D., (803) 758-8052
 CME CREDIT: 1 Hour AMA Category I (per session)

4th WEDNESDAY 12:00 NOON
PATHOLOGY: MORTALITY TEACHING CONFERENCE
 Room 3A110, Building 100, Dorn Veterans' Hospital
 CONTACT: Nicholas J. Pappas, Jr., M.D., (803) 776-4000, Ext. 394 or 399
 CME CREDIT: 1 Hour AMA Category I

2nd & 4th WEDNESDAY 12:00 NOON
PULMONARY MEDICINE CHEST CONFERENCE
 Richland Memorial Hospital, 7th Floor Conference Room
1st & 3rd THURSDAYS 12:00 NOON
 3rd Floor Conference Room, Dorn Veterans' Hospital
 CONTACT: Gerald N. Olsen, M.D., (803) 733-3112

WEDNESDAYS 6:00 P.M.
ORTHOPAEDICS PROBLEM CONFERENCE
 Richland Memorial Hospital Conference Room "P", ACC II
 CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

THURSDAYS 10:00 A.M.
HEMATOLOGY/ONCOLOGY GRAND ROUNDS
 Dorn Veterans' Hospital, 5-West Classroom
 CONTACT: George P. Satiano, M.D., (803) 733-3112

4th THURSDAY 12:00 NOON
G.I. RESIDENTS CONFERENCE
 Dorn Veterans' Hospital, 4th Floor Conference Room
 CONTACT: John Orchard, M.D., (803) 776-4000, Ext. 673

1st THURSDAY 4:00 P.M.
RADIOLOGY DEPT. CONTINUING EDUCATION CONFERENCE
 USC School of Medicine Library Bldg., Room B-116
 CONTACT: David F. Adcock, M.D., (803) 733-3295
 CME CREDIT: 1 Hour AMA Category I

THURSDAYS 12:00 NOON-1:00 P.M.
ENDOCRINE CASE PRESENTATION
 USC School of Medicine Administration Bldg. 2nd Floor Conference Room
 CONTACT: Juraj Osterman, M.D., (803) 733-3112

FRIDAYS 7:00 A.M.
ORTHOPAEDIC SUB-SPECIALTY TOPICS
 Richland Memorial Hospital - Large Private Dining Room
 CONTACT: Edward E. Kimbrough, III, M.D., (803) 765-6812 or 6383

FRIDAYS 9:30-11:30 A.M.
PREVENTIVE MEDICINE GRAND ROUNDS
 USC School of Medicine Library Bldg. Room 327
 CONTACT: Alan Chovil, M.D., (803) 733-3306
 CME CREDIT: 2 Hours AMA Category I

3rd FRIDAY 12:00 NOON-1:30 P.M.

NEUROPSYCHIATRY AND BEHAVIORAL SCIENCES

Dix Conference Room, William S. Hall Psychiatric Institute
CONTACT: Robert J. Pary, M.D., (803) 758-3068

FRIDAYS 1:00 P.M.

INTERNAL MEDICINE GRAND ROUNDS

COLUMBIA, Richland Memorial Hospital Auditorium
SPONSOR: Dept. of Medicine, USC School of Medicine
AUDIENCE: Internal Medicine and Family Practice Physicians
CONTACT: J. O'Neal Humphries, M.D., Chairman, Dept. of Medicine,
(803) 765-6563
CME CREDIT: 1 Hour AMA Category I

SATURDAYS 9:00-10:00 A.M.

SURGICAL GRAND ROUNDS

COLUMBIA, Richland Memorial Hospital Auditorium
SPONSOR: USC School of Medicine, Dept. of Surgery
DESCRIPTION: Lectures and case presentations given by the department
staff and guest speakers
AUDIENCE: Faculty, Residents, Students and Private Clinicians
CONTACT: Carl H. Almond, M.D., (803) 254-4158; James L. Haynes, M.D.,
(803) 765-7452; Frederick L. Greene, M.D., (803) 776-4000, Ext. 582
FACULTY: Staff of Dept. of Surgery and guest lecturers
CME CREDIT: 1 Hour AMA Category I (per session)

GRAND ROUNDS

Medical University of South Carolina

MONDAYS 8:30-9:30 A.M.

PATHOLOGY (ext. 3121) Surgical Pathology Conference
Quadrangle - Room E215

MONDAYS 12:30-1:30 P.M.

RADIOLOGY (ext. 5071) Noon Conference
Hospital — Room B317

MONDAYS 4:00-5:00 P.M.

RADIOLOGY (ext. 5071) Special Imaging Conference
Hospital — Room B312

MONDAYS

RADIOLOGY (ext. 5071) Visiting Radiologist
Hospital — Room 315B

EVERY OTHER MONDAY 10:00 A.M.-12:00 NOON

PATHOLOGY (ext. 3121) Pathology Microscopic Roundtable Conference
Quadrangle Building — Room E215

4th MONDAY 2:30-3:30 P.M.

LABORATORY MEDICINE (ext. 2858) Phlebotomist:
Inservice Update Program
Hospital — 2 West Classroom

TUESDAYS 7:00-8:00 A.M.

SURGERY (ext. 3961) Surgical Grand Rounds - Cancer Conference
2-W Amphitheater — MUH

TUESDAYS 7:00-8:00 A.M.

ORTHOPAEDIC SURGERY (ext. 3934) Grand Rounds — Weekly
MUSC — Room 428

TUESDAYS 11:00 A.M.-12:00 NOON

PSYCHIATRY & BEHAVIORAL SCIENCE (ext. 4050)
Departmental Grand Rounds — MUH Amphitheater

TUESDAYS 12:30-1:30 P.M.

OBSTETRICS/GYNECOLOGY (ext. 4509)
TV Grand Rounds in Obstetrics and Gynecology
MUH — Amphitheater

2nd & 4th TUESDAY 1:30-3:00 P.M.

PSYCHIATRY & BEHAVIORAL SCIENCE 577-5011 (ext. 234)
Case Conference
Veterans' Administration Hospital

TUESDAYS (as scheduled) 9:00-11:00 A.M.

PATHOLOGY (ext. 2456/3121)

Seminar-Tutorial Groups Sessions, Systemic Pathology
Basic Science Building or Quadrangle (where scheduled)

TUESDAYS 8:30-9:30 a.m.

OBSTETRICS/GYNECOLOGY (ext. 4509) Morning Conferences
Clinical Science Building — Room 624

TUESDAYS 2:00-3:30 P.M.

PSYCHIATRY & BEHAVIORAL SCIENCE (ext. 4050)
Adult Outpatient Case Conference
University Service Building — Chairman's Conference Room

2nd & 4th TUESDAY 4:00-5:00 P.M.

PATHOLOGY (ext. 3121) Renal Conference
Basic Science Building — Room 648

1st & 3rd TUESDAY 4:00-5:00 P.M.

PATHOLOGY (ext. 3121)
Gastrointestinal Pathology Conference (GI Conf)
Basic Science Building — Room 648

WEDNESDAYS (except last) 9:00-10:00 A.M.

PATHOLOGY (ext. 2131) Graduate Medical Education in Pathology
Basic Science Building — Room 648

LAST WEDNESDAY 9:00-11:00 A.M.

PATHOLOGY (ext. 3121) Grand Rounds — Pathology
Basic Science Building — Room 648

WEDNESDAYS 10:00-11:00 A.M.

LABORATORY MEDICINE (ext. 2671) Blood Bank Conference
Quadrangle/Pharmacy — Room 209/310

WEDNESDAYS 12:00 NOON-1:00 P.M.

PSYCHIATRY & BEHAVIORAL SCIENCE (ext. 4037)
Psychiatry Journal Club
University Service Building — Chairman's Conference Room

WEDNESDAYS 1:00-2:00 P.M.

LABORATORY SERVICES (577-5011 ext. 466)
Charleston Veterans' Administration Clinical Pathology Conference
Veterans' Administration Hospital — Room B-243

4th WEDNESDAY 2:30-3:30 P.M.

CYTOTECHNOLOGY/HISTOTECHNOLOGY (ext. 2041)
Histotechnology Journal Club
Quadrangle — Room QE 215

WEDNESDAYS 3:00-4:00 P.M.

PATHOLOGY (577-5011 ext. 466)
Charleston Veterans' Administration Medical Center Tumor Board
Veterans' Administration Hospital

WEDNESDAYS 3:00-4:00 P.M.

LABORATORY MEDICINE (ext. 2933) Hematology Conference
Quadrangle — Room B-106

WEDNESDAYS 6:30 P.M.-?

OBSTETRICS/GYNECOLOGY (ext. 4509)
Monthly Journal Club Meeting — Outside Location

WEDNESDAYS 6:00-7:00 P.M.

RADIOLOGY (ext. 5071) Low Country Ultrasound Society
Hospital — Room B-317

THURSDAYS 8:30-9:30 A.M.

OBSTETRICS/GYNECOLOGY (ext. 4509) Morning Conference
Clinical Science Building — Room 624

THURSDAYS 8:00-9:00 A.M.

RADIOLOGY (ext. 5071) Teaching Conference in Neuroradiology
Hospital — Room B-317

THURSDAYS 8:30-10:00 A.M.

PSYCHIATRY & BEHAVIORAL SCIENCE (ext. 4037)
Psychiatry Youth Conference — Clinical Science Building - Room 623C

THURSDAYS 8:30-10:00 A.M.
PSYCHIATRY & BEHAVIORAL SCIENCE (ext. 4037)
 Teaching Case Conference for Consultation/Liaison Service
 Clinical Science Building — Room 623C

THURSDAYS 8:30-10:00 A.M.
PSYCHIATRY (ext. 3051) Child Psychiatry Seminar
 Clinical Science Building — Room 623C

THURSDAYS 9:30-10:30 A.M.
NEUROSURGERY (ext. 2421) Neurosurgery Clinical Conference
 Clinical Science Building — Room 428

THURSDAYS 10:30-11:30 A.M.
NEUROLOGY (ext. 3221) Neurology Grand Rounds
 Clinical Science Building — Room 300

THURSDAYS 10:30-11:45 A.M.
NEUROSURGERY (ext. 2421) Neurosurgery Lecture
 Clinical Science Building — Room 300

THURSDAYS (as scheduled) 9:00-11:00 A.M.
PATHOLOGY (ext. 2456/3121)
 Seminar-Tutorial Group Sessions, Systemic Pathology
 Basic Science Building or Quadrangle (where scheduled)

THURSDAYS 12:00 NOON-1:00 P.M.
PATHOLOGY (ext. 3581/3121) Neuropathology Conference
 Basic Science Building — Room 737

THURSDAYS 1:00-2:00 P.M.
PATHOLOGY & DERMATOPATHOLOGY (ext. 3821/3121)
 Dermatopathology Conference — Quadrangle-Room E215

THURSDAY (once/month) 2:30-3:30 P.M.
LABORATORY MEDICINE (ext. 2671)
 Immunohematology Journal Club — Quadrangle Room 104

THURSDAYS 4:15-5:30 P.M.
NEUROSURGERY (ext. 2421) Neurosurgery Didactic Lectures
 Clinical Science Building — Room 428

1st THURSDAY 5:30-7:30 P.M.
NEUROSURGERY (ext. 2421) Journal Club

FRIDAYS 8:30-10:00 A.M.
MEDICINE/ENDOCRINOLOGY (ext. 2528)
 Endocrinology Journal Club, Endocrinology Research Conference
 Clinical Science Building — Room 910

FRIDAYS 10:00-11:30 A.M.
PSYCHIATRY & BEHAVIORAL SCIENCE
 Teaching Case Conference, Adult Inpatient
 MUH — Room 7W Conference Room

FRIDAYS 12:00 NOON-1:00 P.M.
PATHOLOGY (ext. 3556/3121) Clinico-Pathologic Conference (CPC)
 Mu Hospital — Room 2W Amphitheater

FRIDAYS 2:30-4:00 P.M.
MEDICINE (ext. 2000) Division Rounds (Case Conference)
 of the Division of Rheumatology & Immunology
 Clinical Science Building — Room 912

FRIDAYS 4:00-5:30 P.M.
MEDICINE/ENDOCRINOLOGY (ext. 2528)
 Endocrinology Case Conference
 Clinical Science Building — Room 906E

FRIDAYS 8:30-9:30 A.M.
PATHOLOGY (ext. 3121) Surgical Pathology Conference
 Quadrangle — Room E215

FRIDAYS 12:30-1:30 P.M.
RADIOLOGY (ext. 5071) Noon Conference
 Hospital — Room B317

FRIDAYS 4:00-5:00 P.M.
RADIOLOGY (ext. 5071) Special Imaging Conference
 Hospital — Room B312

FRIDAYS
RADIOLOGY (ext. 5071) Visiting Radiologist
 Hospital — Room 315B

FRIDAYS 8:30-9:30 A.M.
OBSTETRICS/GYNECOLOGY (ext. 4509) Morning Conferences
 Clinical Science Building — Room 624

CONTINUING MEDICAL EDUCATION COMMITTEE

James Long, M.D., Spartanburg General Hospital, Spartanburg 29303 — CHAIRMAN
 Frederick G. Jones, M.D., Memorial Hospital, Anderson 29621
 R. Ramsey Mellette, M.D., MUSC-171 Ashley Avenue, Charleston 29425
 William R. DeLoache, M.D., 701 Grove Road, Greenville 29605
 Benton Montgomery, M.D., Family Practice Center, Greenwood 29646
 O'Neill Barrett, M.D., USC School of Medicine, Columbia 29208
 James G. Halford, Jr., M.D., 600 N. Fant Street, Anderson 29621
 Grady H. Hendrix, M.D., MUSC-171 Ashley Avenue, Charleston 29425
 Edward Booker, M.D., Broad Street, Walhalla 29691
 James L. Haynes, M.D., 3321 Medical Park Road, #300, Columbia 29203
 Kay McFarland, M.D., USC, Columbia 29208
 N.B. Baroody, M.D., 501 S. Coit Street, Florence 29501
 J. Daniel Love, M.D., Richland Memorial Hospital, Columbia 29203
 H. Biemann Othersen, Jr., M.D., MUSC-171 Ashley Avenue, Charleston 29425
 Warren C. Lovett, M.D., General Hospital, Spartanburg 29303
 O. Marion Burton, M.D., Memorial Hospital, Anderson 29621 — SPEAKER

Editorial

LEONARD'S LEGACY

Reflecting over the past year during this Christmas season, we are grateful for the leadership of Leonard Douglas and saddened by his in-office death as president of our association. We remember his character and his untiring efforts on behalf of organized medicine, so eloquently expressed in last month's editorial by his friend, Don Kilgore.

At the time of this death, Leonard Douglas was working tirelessly for a cause which he himself — as a highly-respected small-town family practitioner — probably had less reason to be concerned with than nearly anyone: the pressing need for tort reform.

A decade has passed since establishment of a Joint Underwriting Association (JUA) in South Carolina met a major crisis in malpractice insurance availability. We now brace against a second crisis in malpractice coverage. In the past ten years, 1,700 liability claims have been filed against South Carolina physicians. The JUA now faces a deficit of 18 million dollars, and the Patients' Compensation Fund faces a deficit of 13 million dollars. Both of these will require assessments and higher premiums. Some physicians will reconsider the nature of their practices; others will debate whether to continue practicing at all. Hardly unique to South Carolina, this scenario is being repeated in state after state.

A decade ago, many persons articulated the root of the problem: the nature of our tort liability system as it affects medicine. This problem is still with us. We still witness a classic struggle between the interests of medicine and the interests of the Trial Lawyers' Association of America. The interests of society as a whole sometimes seem to be lost in the shuffle.

To persons other than attorneys, the word "tort" brings vague discomfort (perhaps like the word "lesion" to persons other than physicians) — everyone has heard it but few know it as part of their daily vocabularies. The Encyclopedia Britannica defines the law of torts as being "that part of the law which provides remedies for a wide

range of unlawful conduct that is either dangerous to life and limb, causes mental anguish, unjustifiably damages personal reputations, or violates certain rights. . . ." Read on! Turning to the encyclopedia's section on "negligence and insurance liability law," we learn that "in many countries the courts have tended to apply increasingly strict standards in adjudicating negligence." This has been termed the trend toward absolute liability — which enables the plaintiff to recover for almost any accidental injury, even if the defendant can demonstrate the use of "due care" and therefore be not negligent in the traditional sense. As an example, a court awarded huge sums to persons who contracted poliomyelitis from a vaccine, even though the vaccine's manufacturer could demonstrate that every possible, known precaution had been meticulously followed.

This problem, as it affects medicine in the United States and other countries, is reflected in the fact that so many claims are brought with little or no evidence of negligence. The mere filing of a lawsuit requires a defense, which as we all know can be extremely expensive. Allowed to receive up to 50 percent of the award under the contingency fee system, attorneys have ample incentive to file claims as an entrepreneurial venture. A Brookings Institute report suggests that up to 80 percent of malpractice insurance premiums go toward legal and administrative costs. By conservative estimates, no more than 30 to 40 percent of premiums goes toward compensating patients.

Nearly every South Carolina physician could offer a personal perspective, whether based on involvement as an alleged joint tortfeasor, as a witness, or as a concerned friend. A recent case in which it was my misfortune to be called as a witness served as a reminder of the pernicious nature of our current tort liability system.

All evidence indicated that the patient's life had been saved on at least two occasions by those whom he accused. He sued despite appropriate care and indeed appropriate referrals following which he had declined undergoing a curative

operation. He seemed to have brought suit against every physician he had seen, including physicians who had nothing to do with the problem at hand. His lawyer brought the case to the courthouse without a single expert witness. And yet the judge permitted the case to go to trial.

Although the court ruled in the defendants' favor after three days of testimony, it is pointless to assert that anyone "wins" in such situations. For the defending physicians, the monetary losses from time away from practice far exceeded the modest physicians' fees incurred by the plaintiff. Malpractice suits cause incalculable mental anguish and damage to reputations (returning to our definition of a tort, above), even when totally unfounded. One looks at optimistic, altruistic medical students and grieves for what most of them will probably have to endure. We still see the bumper stickers: "SUPPORT YOUR LOCAL TRIAL LAWYER — SEND YOUR SON (or daughter) TO MEDICAL SCHOOL."

The American Trial Lawyers' Association asserts that "the cause of malpractice litigation is medical negligence." This statement seems difficult to defend when we have clear evidence (as in the case cited above) that plaintiffs reach the courthouse with no case for negligence. Public opinion polls indicate what we all suspect: lawsuits are spawned by the growing public awareness (sometimes encouraged by advertising) that anyone can sue anyone and stand to make a profit.

The SMCA's position on needed reform in the South Carolina law of torts includes the following points:

- (1) the need to modify the rules of evidence to provide for a stronger defense;
- (2) the need to allow collateral sources of compensation, such as Workmen's Compensation, to be considered as payment toward the damage assessed;
- (3) modification of the statute of limitations concerning infant liability;
- (4) establishment of a limit of \$100,000 for noneconomic damages such as pain, suffering, and mental anguish;
- (5) establishment of a sliding scale of payments to attorneys based on the amount of the award instead of the current across-the-board contingency fee;
- (6) elimination of a separate trial for damages only; and

- (7) punitive damages may be awarded only upon a showing by clear and convincing evidence that the alleged misconduct was intentional and with malice.

In my opinion, these are conservative recommendations. One can argue that they do not go far enough.

The best solution still seems to be the requirement for preliminary arbitration panels involving lawyers, physicians, and lay persons. As done elsewhere, these panels decide whether or not a suit contains merit and whether there are grounds for considering negligence. Should such grounds not be established, the plaintiff might proceed with litigation — at his own potential risk for bearing the court costs.

The American Trial Lawyers' Association asserts that our present tort liability system represents "the poor man's key to the court house door." The trial lawyers have a point. However, this argument contains the same weakness as the argument that "every citizen deserves the most costly, intensive medical care possible, irrespective of his or her ability to pay." Society can no longer afford these extravagances, however desirable they might seem in theory.

Several years ago, a prominent American physician suggested to me a means by which we might modify at least some of the inherent problems in our current legal system. We should start a groundswell of public opinion leading to a constitutional amendment limiting (by percentage) the number of lawyers in state legislatures. Given the option, most of us usually act in our own self-interest; lawyers are no better and no worse than the rest of us. Thus, laws frequently favor the lawyers. This may explain, at least in part, why far too many of our brightest young people go to law school and why far too few become engineers. In Japan, the situation is reversed — consider the economic consequences!

The JUA seems to have been merely a hot compress; the abscess has not been incised and drained.

Let all South Carolina physicians support our efforts to achieve tort reform. Let this remain as Leonard's legacy.

— CSB

ON THE COVER: THOMAS PEARCE BAILEY, M.D., 1832-1904

1865 marked the end of an era in South Carolina and throughout the south. The disaster of the 60's had created havoc in the land and altered large sections of the social infrastructure of the country. At no time in the evolution of medicine in South Carolina was there a more abrupt change in the pattern of certain elements of medical practice. Of particular interest was the change in the quality of medicine available for black South Carolinians. In the rural agricultural society of the pre-Confederate War era, the medical care of black slaves was attended to with a quality that took an additional 100 years to regain following the disruption of the plantation system.

There is very good evidence to support the opinion that the quality of medical care extended to slaves in South Carolina was quite good. Of course, variations occurred depending on management, location and size of certain plantations, but the health care rendered by a plantation owner toward his slaves was equal to that rendered himself and his family and has been noted to have been far more extensive than many of the less affluent members of the white population during the same time.

Frequently, estates provided slave hospitals and several of these plantations, such as Prospect Hill on Edisto Island, were recognized for the quality of care rendered the negro population in the plantation's unusual brick hospital. In past writing there has been some tendency to suggest that plantation owners were only concerned for the health of their slave population for financial reasons, but evidence indicates that this was certainly not a universal pattern. A report written by James R. Sparkman, M.D., to Benjamin Allston (a major plantation owner in the Georgetown area) describes his extensive experiences as a plantation physician during a 22-year period. He described the regular medical attention that he rendered to over 3,000 slaves on 20 to 30 rice plantations. He frequently reported that the native, or southern

plantation owners, were generally more kind, considerate and indulgent of their slaves than were northerners, who he reported to be "impatient and exacting without intending any unkindness," stating that "they are ignorant of the negro character and fail to secure the attachment of the slaves" as was frequently the tendency of the southern master. He again reported that the quality of medical care for the slave was the same as that for the plantation owner and plantation drug books and medical records attest to this.

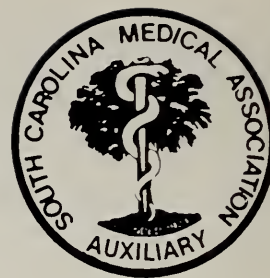
Following the Confederate War, major changes occurred and the previous health care provided at the plantation owner's expense ceased to exist. Prior to 1865, many diseases which later became rampant in black populations, i. e., syphilis, rarely occurred during slavery times. The death rate of whites and blacks was nearly the same throughout South Carolina in the pre-1865 period and in Charleston, the death rate was far better than that in northern areas. It was reported that the mortality of free negroes in northern cities was three times that of the slaves in Charleston.

It was during this period of transition that Thomas Pearce Bailey, M.D., practiced medicine in the Georgetown area of South Carolina. No doubt he had ample opportunity to witness this change, having graduated from the Medical College at Charleston in 1853 and practicing in the Santee and Georgetown areas throughout his medical career. His active interest in the promotion of better medical conditions in his native state led him into organized medicine and he was elected as President of the South Carolina Medical Association in 1891.

Biographical data on Dr. Bailey are extremely limited, and further information on his life and background is solicited by the Waring Historical Library.

—THOMAS M. LELAND, M.D., Ph.D.

SOUTH CAROLINA MEDICAL ASSOCIATION AUXILIARY



CONFLUENCE — 1985

As October 6 approached, my interest in attending the confluence began to wane; after all, I had never met anyone else going from South Carolina. I really did not know a lot about AMA Auxiliary, and I had never traveled to Chicago before, much less alone!

As the plane left Charlotte, I asked to have my future roommate pointed out by the stewardess, I introduced myself to Sheila Yates and upon arrival in Chicago, we were comfortable and enjoying each other's company. This was just the beginning of a wonderful, exciting, jam-packed two days. Never have I been involved with anything that had more meaning to me first as a person, second as the wife of a physician and mother to our children, and third as a caring member of a community!

Our first day began with breakfast and a talk by Frances G. Edwards on leadership strategies. We then proceeded to the first of three "breakout sessions" — where we met in smaller groups of about 25 or more, and listened to and participated in discussions on issues of interest and concern to all Auxiliary members. Of the six I chose to attend, all but one were presented in an informative manner, by knowledgeable professionals recognized in their fields. I came away with a better understanding of the important issues confronting us today: malpractice and how it affects the family; impairment — the physician and his family; AMPAC; community services for older Americans; changing of the guard within the Auxiliary and others. There was something for everyone. Even lunch and dinner had a speaker, movie, or some presentation. I particularly enjoyed Dr. Harrison L. Rogers, Jr., President of AMA, speak of his optimism for medicine and the importance of AMA and Auxiliaries working together.

The entire confluence was *very* well organized and everything ran smoothly — the dedicated, hardworking AMA Auxiliary staff was much in evidence. The parade of states featured small displays of state projects and fundraising activities, where we shared free ideas, brochures, and "how to" booklets on a variety of topics. I did find that nearly all states had projects concerned with the health of our children and of older people. The AMA Auxiliary displayed racks and racks of all the different material they make available.

I honestly am inept at explaining how important and vital to us the American Medical Association Auxiliary, Inc. really is! I will also confess that I will *never again* fail to send in my National dues! I do not know of any organization that works for us, our physician spouse, our families, and our communities as does AMA Auxiliary — by providing up-to-date information on areas of concern, supporting scholarships and loans in health careers, and in providing a vehicle for a unified voice in health and medical legislation. I know that they have well used my \$15!! If you ever have the opportunity to attend the confluence or anything associated with the Auxiliary, please do not hesitate to go — you will be the one to benefit I am sure! If you do not pay National dues, please do so *today!* I promise the return on your money will benefit you, your family, your community, and your county!

ANN MCQUEEN (Mrs. Don)
President-Elect,
York County Medical
Society Auxiliary

FINANCIAL CHECKUP

MARTIN LEFKOWITZ
Certified Financial Planner
Tax Shelter Co-Ordinator: E.F. Hutton

Vol. 5, Issue No. 12

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WHAT YOU SHOULD KNOW BEFORE YOU BUY STOCK.

Putting the Fundamentals to Work.

Once you've looked at all the aspects of your company, there's still some work to do. Characteristics such as net earnings, sales record and price/earnings ratio are put to their best use when used to make even more comparisons. For example, a company's net earnings for a particular year can be compared to previous years' earnings to see if the company is headed toward growth. The tools of fundamental analysis can also be used to compare figures from company to company to see how your company compares to others in its industry.

And fundamental analysis could be just the beginning. There are other, more "technical" aspects to consider as well.

TECHNICALLY SPEAKING.....

Let's say you've chosen your company and, based on your research, determined it's in fine shape. That's great...maybe. It's great if the market looks favorably on your choice. But it's not so great - and you could still lose your shirt despite your painstaking efforts - if the market environment paints a grim picture for your company and/or its industry.

How can you determine if the current market is favorable toward the industry in which you're thinking of investing? And, moreover, how can you be sure you've timed your investment for best results? "Technical analysis" can help.

Unlike fundamental analysis, technical analysis is the study of supply and demand of stocks. While fundamental analysis strives to explain why a stock's price is moving in a certain direction by looking at company, industry and broader economic characteristics, technical analysis concentrates on the market environment, taking its "pulse" to predict when a stock's price will move and in what direction.

From a technician's viewpoint, any stock is only as good as the market of which it's a part. And so the seasoned technician, armed with various charts and broad price trend statistics, sets out to get a feel for the current market and how it will affect stocks in various industries. In fact, many analysts use as many as 100 indicators to try to get an accurate picture of a stock's standing in the market. Sound prohibitive?

There are some techniques with which you may want to experiment on your own, too. Here's how you can start...

LOOK FOR PATTERNS

Analyzing the market to determine broad patterns of action is the focal point of technical analysis. In accordance, breadth-momentum indicators focus on trading volume patterns and price trends. A popular method of establishing such trends for a given stock is with the help of bar charts, the most popular type of stock chart. These are easily constructed by keeping a record of the highest, lowest and closing prices each day (or week, for a weekly bar chart) as well as the number of shares traded daily (weekly). From this information, you can get a good look at various patterns that emerge over time; and this, in turn, can lead you to certain conclusions on how the stock will react in the future, based on past trends.

Two of the most valuable and well-known patterns are price support and resistance levels. Support levels are the price at which the stock suddenly becomes attractive and people start buying it, causing the price to rise. In contrast, when a stock hits a resistance level, it may be the time to sell.

For a broader perspective, you may want to utilize the moving average(s) of a stock. This method helps you watch a stock's progress by relating the stock price to its "moving average." This cues you in on how the stock is performing now as compared to how it has been performing over a longer period of time. And, the Beta, a measure of the average percentage change in the price of a stock relative to the percentage change of a market index (i.e., the S&P Index), is an even broader-reaching tool. Generally, the higher the beta, the more volatile the stock.

USING THE ECONOMY TO PREDICT THE MARKET.

Technical indicators are another way of applying technical analysis. There are hundreds of such indicators, which can generally be found in business publications and newspapers. Two of the most widely used ones are the index of 12 leading indicators and the money supply indicator.

Within the category of technical indicators are sentiment indicators. These monitor the activity of market participants, including small investors, large banks and insurance companies, mutual fund and pension fund managers, member firms of the various exchanges and exchange specialists. Sentiment indicators, in general, provide limited help in technical analysis and some even signal the technician to go against the flow of public buying patterns.

TAKE THE NEXT STEP.

As you can see, the search for the perfect common stock is at best an imperfect science. But by examining as many factors as you can and seeking expert help where necessary, you may be able to bridge the gap between your financial dreams and realities. Granted, nothing is a "sure thing" when it comes to the stock market, but there's also no replacement for a smart, well-thought out investment strategy. Remember, choosing to invest in common stock was just the first step. Now, why not take the second one?

FURTHER INFORMATION

If you would like to receive further information on any of the topics covered in this newsletter, please write to Martin Lefkowitz, CFP, E.F. Hutton & Company, Inc. 2700 Middleburg Drive, Suite 200, Columbia, SC 29204; or Call (800) 922-1112.

* * * * *

The information contained herein has been obtained from sources believed reliable, but is not necessarily complete and cannot be guaranteed. Any opinions expressed are subject to change without notice. Neither the information presented nor any opinion expressed constitutes a representation by us or a solicitation of the purchase or sale of any securities. South Carolina Medical Association and E.F. Hutton & Company, Inc. 1985.

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